AMENDMENT TO H.R. 3046, AS REPORTED

OFFERED BY MR. BILIRAKIS

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Regulatory, Appeals, Contracting, and Education Reform Act of 2001''.

(b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this Act an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) BIPA; SECRETARY.—In this Act:

(1) BIPA.—The term ''BIPA'' means the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, as enacted into law by section 1(a)(6) of Public Law 106–554.

(2) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(d) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. FINDINGS.

Congress finds the following:

(1) The overwhelming majority of providers of services, physicians, practitioners, facilities, and suppliers in the United States are law-abiding persons who provide important health care services to patients each day.

(2) The Secretary of Health and Human Services should work to streamline paperwork requirements under

the medicare program and communicate clearer instructions to providers of services, physicians, practitioners, facilities, and suppliers so that they may spend more time caring for patients.

SEC. 3. CONSTRUCTION.

(a) NO EFFECT ON LEGAL AUTHORITY.—Nothing in this Act shall be construed to compromise or affect existing legal authority for addressing fraud or abuse, whether it be criminal prosecution, civil enforcement, or administrative remedies, including under sections 3729 through 3733 of title 31, United States Code (known as the False Claims Act).

(b) NO EFFECT ON MEDICARE WASTE, FRAUD, AND ABUSE EFFORTS.—Nothing in this Act shall be construed to prevent or impede the Department of Health and Human Services in any way from its ongoing efforts to eliminate waste, fraud, and abuse in the medicare program.

(c) CLARIFICATION RELATED TO MEDICARE TRUST FUNDS.—The consolidation of medicare administrative contracting set forth in this Act does not constitute (or reflect any position on the issue of) consolidation of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund.

TITLE I—REGULATORY REFORM

SEC. 101. ISSUANCE OF REGULATIONS.

(a) CONSOLIDATION OF PROMULGATION TO ONCE A MONTH.—

(1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh) is amended by adding at the end the following new subsection:

''(d)(1) Subject to paragraph (2), the Secretary shall issue final (including interim final) regulations to carry out this title only on one business day of every month.

''(2) The Secretary may issue a final regulation described in paragraph (1) on any other day than the day described in paragraph (1) if the Secretary—

"(A) finds that issuance of such regulation on another day is necessary to comply with requirements under law; or

"(B) finds that with respect to that regulation the limitation of issuance on the date described in paragraph (1) is contrary to the public interest.

If the Secretary makes a finding under this paragraph, the Secretary shall include such finding, and brief statement of the reasons for such finding, in the issuance of such regulation.".

(2) REPORT ON PUBLICATION OF REGULATIONS ON A QUARTERLY BASIS.—Not later than 3 years after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the feasibility of requiring that regulations described in section 1871(d) of the Social Security Act be promulgated on a quarterly basis rather than on a monthly basis.

(3) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to regulations promulgated on or after the date that is 30 days after the date of the enactment of this Act.

(b) REGULAR TIMELINE FOR PUBLICATION OF FINAL REGULATIONS.—

(1) IN GENERAL.—Section 1871(a) (42 U.S.C. 1395hh(a)) is amended by adding at the end the following new paragraph:

"(3)(A) The Secretary, in consultation with the Director of the Office of Management and Budget, shall establish a regular timeline for the publication of final regulations based on the previous publication of a proposed regulation or an interim final regulation.

"(B) With respect to publication of final regulations based on the previous publication of a proposed regulation, such timeline may vary among different regulations based on differences in the complexity of the regulation, the number and scope of comments received, and other relevant factors.

"(C)(i) With respect to the publication of final regulations based on the previous publication of an interim final regulation—

"(I) subject to clause (ii), the Secretary shall publish the final regulation within the 12-month period that begins on the date of publication of the interim final regulation;

"(II) if a final regulation is not published by the deadline established under this subparagraph, the interim final regulation shall not continue in effect unless the Secretary publishes a notice described in clause (ii) by such deadline; and

"(III) the final regulation shall include responses to comments submitted in response to the interim final regulation.

"(ii) If the Secretary determines before the deadline otherwise established in this subparagraph that there is good cause, specified in a notice published before such deadline, for delaying the deadline otherwise applicable under this subparagraph, the deadline otherwise established under this subparagraph shall be extended for such period as the Secretary specifies in such notice.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act. The Secretary shall provide for an appropriate transition to take into account the backlog of previously published interim final regulations.

(c) LIMITATIONS ON NEW MATTER IN FINAL REGULATIONS.—

(1) IN GENERAL.—Section 1871(a) (42 U.S.C. 1395hh(a)), as amended by subsection (b), is further amended by adding at the end the following new paragraph:

"(4) Insofar as a final regulation (other than an interim final regulation) includes a provision that is not a logical outgrowth of the relevant notice of proposed rulemaking relating to such regulation, that provision shall be treated as a proposed regulation and shall not take effect until there is the further opportunity for public comment and a publication of the provision again as a final regulation.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to final regulations published on or after the date of the enactment of this Act.

SEC. 102. COMPLIANCE WITH CHANGES IN REGULATIONS AND POLICIES.

(a) NO RETROACTIVE APPLICATION OF SUBSTANTIVE CHANGES.—

(1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh), as amended by section 101(a), is amended by adding at the end the following new subsection:

''(e)(1)(A) A substantive change in regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability under this title shall not be applied (by extrapolation or otherwise) retroactively to items and services furnished before the effective date of the change, unless the Secretary determines that—

''(i) such retroactive application is necessary to comply with statutory requirements; or

''(ii) failure to apply the change retroactively would be contrary to the public interest.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to substantive changes issued on or after the date of the enactment of this Act.

(b) TIMELINE FOR COMPLIANCE WITH SUBSTANTIVE CHANGES AFTER NOTICE.—

(1) IN GENERAL.—Section 1871(e)(1), as added by subsection (a), is further amended by adding at the end the following:

''(B) A compliance action may be made against a provider of services, physician, practitioner, facility, or supplier with respect to noncompliance with a substantive change referred to in subparagraph (A) only for items and services furnished on or after the effective date of the change.

''(C)(i) Except as provided in clause (ii), a substantive change referred to in subparagraph (A) may not take effect before the end of the 30-day period that begins on the date that

the Secretary has issued or published, as the case may be, the substantive change.

''(ii) The Secretary may provide for such a substantive change to take effect on a date that precedes the end of the 30-day period under clause (i) if the Secretary finds that waiver of such 30-day period is necessary to comply with statutory requirements or that the application of such 30-day period is contrary to the public interest. If the Secretary provides for an earlier effective date pursuant to this clause, the Secretary shall include in the issuance or publication of the substantive change a finding described in the first sentence, and a brief statement of the reasons for such finding.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to compliance actions undertaken on or after the date of the enactment of this Act.

SEC. 103. REPORT ON REGULATORY BURDENS.

Section 1871 (42 U.S.C. 1395hh), as amended by sections 101(a) and 102, is amended by adding at the end the following new subsection:

''(f)(1) Not later than 2 years after the date of the enactment of this subsection, and every 2 years thereafter, the Secretary shall submit to Congress a report with respect to the administration of this title and areas of inconsistency or conflict among the various provisions under law and regulation.

''(2) In preparing a report under paragraph (1), the Secretary shall collect—

''(A) information from beneficiaries, providers of services, physicians, practitioners, facilities, and suppliers, and from the individual under section 404 of the Medicare Regulatory, Appeals, Contracting, and Education Reform Act of 2001 with respect to such areas of inconsistency and conflict; and

''(B) information from medicare contractors that tracks the nature of written and telephone inquiries.

''(3) A report under paragraph (1) shall include a description of efforts by the Secretary to reduce such inconsistency or conflicts, and recommendations for legislation or administrative

action that the Secretary determines appropriate to further reduce such inconsistency or conflicts.''.

SEC. 104. GAO REPORT ON THE SUSTAINABLE GROWTH RATE AND REGULATORY COSTS.

Not later than 18 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the accuracy of the sustainable growth rate (under section 1848(f) of the Social Security Act, 42 U.S.C. 1395w–4(f)) for 2002 and succeeding years in accounting for regulatory costs imposed on physicians.

SEC. 105. GAO REPORT ON REQUIREMENT FOR SUBMISSION OF CLAIMS FOR CATEGORICALLY EXCLUDED DENTAL SERVICES.

Not later than 18 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the extent to which—

(1) group health plans or other third party payors require that claims for medicare categorically excluded dental services be denied by under the medicare program before the plan or payor will make payment for such claims; and

(2) medicare beneficiaries request dentists to submit claims for such categorically excluded dental services.

TITLE II—APPEALS PROCESS REFORM

SEC. 201. TRANSFER OF RESPONSIBILITY FOR MEDICARE APPEALS.

(a) TRANSITION PLAN.—

(1) IN GENERAL.—Not later than October 1, 2002, the Commissioner of Social Security and the Secretary shall develop and transmit to Congress and the Comptroller General of the United States a plan under which the functions of administrative law judges responsible for hearing cases under title XVIII of the Social Security Act (and related provisions in title XI of such Act) are transferred from the responsibility of the Commissioner and the Social Security Administration to the Secretary and the Department of Health and Human Services.

(2) CONTENTS.—The plan shall include information on the following:

(A) WORKLOAD.—The number of such administrative law judges and support staff required now and in the future to hear and decide such cases in a timely manner, taking into account the current and anticipated claims volume, appeals, number of beneficiaries, and statutory changes.

(B) COST PROJECTIONS.—Funding levels required for fiscal year 2004 and subsequent fiscal years under this subsection to hear such cases in a timely manner.

(C) TRANSITION TIMETABLE.—A timetable for the transition.

(D) REGULATIONS.—The establishment of specific regulations to govern the appeals process.

(E) CASE TRACKING.—The development of a unified case tracking system that will facilitate the maintenance and transfer of case specific data across both the fee-for-service and managed care components of the medicare program.

(F) FEASIBILITY OF PRECEDENTIAL AUTHORITY.—The feasibility of developing a process to give decisions of the Departmental Appeals Board in the Department of Health and Human Services addressing broad legal issues binding, precedential authority.

(G) ACCESS TO ADMINISTRATIVE LAW JUDGES.—The feasibility of filing appeals with administrative law judges electronically, and the feasibility of conducting hearings using tele- or video-conference technologies.

(3) ADDITIONAL INFORMATION.—The plan may also include recommendations for further Congressional action, including modifications to the requirements and deadlines established under section 1869 of the Social Security Act (as amended by sections 521 and 522 of BIPA, 114 Stat. 2763A–534).

(4) GAO EVALUATION.—The Comptroller General of the United States shall evaluate the plan and, not later

than April 1, 2003, shall submit to Congress a report on such evaluation.

(b) TRANSFER OF ADJUDICATION AUTHORITY.—

(1) IN GENERAL.—Not earlier than July 1, 2003, and not later than October 1, 2003, the Commissioner of Social Security and the Secretary shall implement the transition plan under subsection (a) and transfer the administrative law judge functions described in such subsection from the Social Security Administration to the Secretary.

(2) ASSURING INDEPENDENCE OF JUDGES.—The Secretary shall assure the independence of judges performing the administrative law judge functions transferred under paragraph (1) from the Centers for Medicare & Medicaid Services and its contractors.

(3) GEOGRAPHIC DISTRIBUTION.—The Secretary shall provide for an appropriate geographic distribution of judges performing the administrative law judge functions transferred under paragraph (1) throughout the United States to ensure timely access to such judges.

(4) HIRING AUTHORITY.—Subject to the amounts provided in advance in appropriations Act, the Secretary shall have authority to hire administrative law judges to hear such cases, giving priority to those judges with prior experience in handling medicare appeals and in a manner consistent with paragraph (3), and to hire support staff for such judges.

(5) FINANCING.—Amounts payable under law to the Commissioner for judges performing the administrative law judge functions transferred under paragraph (1) from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund shall become payable to the Secretary for the functions so transferred.

(6) SHARED RESOURCES.—The Secretary shall enter into such arrangements with the Commissioner as may be appropriate with respect to transferred functions of administrative law judges to share office space, support staff, and

other resources, with appropriate reimbursement from the Trust Funds described in paragraph (5).

(c) INCREASED FINANCIAL SUPPORT.—In addition to any amounts otherwise appropriated, to ensure timely action on appeals before administrative law judges and the Departmental Appeals Board consistent with section 1869 of the Social Security Act (as amended by section 521 of BIPA, 114 Stat. 2763A–534), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to the Secretary such sums as are necessary for fiscal year 2003 and each subsequent fiscal year to—

(1) increase the number of administrative law judges (and their staffs) under subsection (b)(4),

(2) improve education and training opportunities for administrative law judges (and their staffs), and

(3) increase the staff of the Departmental Appeals Board.

(d) CONFORMING AMENDMENT.—Section 1869(f)(2)(A)(i) (42 U.S.C. 1395ff(f)(2)(A)(i)), as added by section 522(a) of BIPA 114 Stat. 2763A–543, is amended by striking ''of the Social Security Administration''.

SEC. 202. EXPEDITED ACCESS TO JUDICIAL REVIEW.

(a) IN GENERAL.—Section 1869(b) (42 U.S.C. 1395ff(b)), as amended by section 521 of BIPA, 114 Stat. 2763A–534, is amended—

(1) in paragraph (1)(A), by inserting '', subject to paragraph (2),'' before ''to judicial review of the Secretary's final decision''; and

(2) by adding at the end the following new paragraph:

''(2) EXPEDITED ACCESS TO JUDICIAL REVIEW.—

''(A) IN GENERAL.—The Secretary shall establish a process under which a provider of services or supplier that furnishes an item or service or a beneficiary who has filed an appeal under paragraph (1) may obtain access to judicial review when a review panel (described in subparagraph (D)), on its own motion or at the re-

quest of the appellant, determines that the Departmental Appeals Board does not have the authority to decide the question of law or regulation relevant to the matters in controversy and that there is no material issue of fact in dispute. The appellant may make such request only once with respect to a question of law or regulation for a specific matter in dispute in a case of an appeal.

''(B) PROMPT DETERMINATIONS.—If, after or coincident with appropriately filing a request for an administrative hearing, the appellant requests a determination by the appropriate review panel that the Departmental Appeals Board does not have the authority to decide the question of law or regulations relevant to the matters in controversy and that there is no material issue of fact in dispute and if such request is accompanied by the documents and materials as the appropriate review panel shall require for purposes of making such determination, such review panel shall make a determination on the request in writing within 60 days after the date such review panel receives the request and such accompanying documents and materials. Such a determination by such review panel shall be considered a final decision and not subject to review by the Secretary.

''(C) ACCESS TO JUDICIAL REVIEW.—

''(i) IN GENERAL.—If the appropriate review panel—

''(I) determines that there are no material issues of fact in dispute and that the only issue is one of law or regulation that the Departmental Appeals Board does not have authority to decide; or

''(II) fails to make such determination within the period provided under subparagraph (B);

then the appellant may bring a civil action as described in this subparagraph.

"(ii) DEADLINE FOR FILING.—Such action shall be filed, in the case described in—

"(I) clause (i)(I), within 60 days of the date of the determination described in such subparagraph; or

"(II) clause (i)(II), within 60 days of the end of the period provided under subparagraph (B) for the determination.

"(iii) VENUE.—Such action shall be brought in the district court of the United States for the judicial district in which the appellant is located (or, in the case of an action brought jointly by more than one applicant, the judicial district in which the greatest number of applicants are located) or in the district court for the District of Columbia.

"(iv) INTEREST ON ANY AMOUNTS IN CONTROVERSY.—Where a provider of services or supplier seeks judicial review pursuant to this paragraph, the amount in controversy (if any) shall be subject to annual interest beginning on the first day of the first month beginning after the 60-day period as determined pursuant to clause (ii) and equal to the rate of interest on obligations issued for purchase by the Federal Supplementary Medical Insurance Trust Fund for the month in which the civil action authorized under this paragraph is commenced, to be awarded by the reviewing court in favor of the prevailing party. No interest awarded pursuant to the preceding sentence shall be deemed income or cost for the purposes of determining reimbursement due providers of services and suppliers under this Act.

"(D) REVIEW PANEL DEFINED.—For purposes of this subsection, a 'review panel' is a panel of 3 members from the Departmental Appeals Board, selected

for the purpose of making determinations under this paragraph.''.

(b) APPLICATION TO PROVIDER AGREEMENT DETERMINATIONS.—Section 1866(h)(1) (42 U.S.C. 1395cc(h)(1)) is amended—

(1) by inserting ''(A)'' after ''(h)(1)''; and

(2) by adding at the end the following new subparagraph:

''(B) An institution or agency described in subparagraph (A) that has filed for a hearing under subparagraph (A) shall have expedited access to judicial review under this subparagraph in the same manner as providers of services, suppliers, and beneficiaries may obtain expedited access to judicial review under the process established under section 1869(b)(2). Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1819 during the pendency of an appeal under this subparagraph.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to appeals filed on or after October 1, 2003.

SEC. 203. EXPEDITED REVIEW OF CERTAIN PROVIDER AGREEMENT DETERMINATIONS.

(a) TERMINATION AND IMMEDIATE SANCTIONS.—The Secretary shall develop and implement a process to expedite proceedings under sections 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)) in which the sanction of termination of participation or a sanction described in clause (i) or (iii) of section 1819(h)(2)(B) of such Act (42 U.S.C. 1395i–3(h)(2)(B)) has been imposed. Under such process priority shall be provided in cases of termination.

(b) INCREASED FINANCIAL SUPPORT.—In addition to any amounts otherwise appropriated, to reduce by 50 percent the average time for administrative determinations on appeals under section 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to the Secretary such additional sums for fiscal year

2003 and each subsequent fiscal year as may be necessary to increase the number of administrative law judges (and their staffs) at the Departmental Appeals Board of the Department of Health and Human Services and to educate such judges and staff on long-term care issues.

SEC. 204. REVISIONS TO MEDICARE APPEALS PROCESS.

(a) TIMEFRAMES FOR THE COMPLETION OF THE RECORD.—Section 1869(b) (42 U.S.C. 1395ff(b)), as amended by section 521 of BIPA, 114 Stat. 2763A–534, and as amended in section 202(a), is further amended by adding at the end the following new paragraph:

"(3) TIMELY COMPLETION OF THE RECORD.—

"(A) DEADLINE.—Subject to subparagraph (B), the deadline to complete the record in a hearing before an administrative law judge or a review by the Departmental Appeals Board is 90 days after the date the request for the appeal is filed.

"(B) EXTENSIONS FOR GOOD CAUSE.—The person filing a request under subparagraph (A) may request an extension of such deadline for good cause. The administrative law judge, in the case of a hearing, and the Departmental Appeals Board in the case of a review, may extend such deadline based upon a finding of good cause to a date specified by such individual.

"(C) DELAY IN DECISION DEADLINES UNTIL COMPLETION OF RECORD.—Notwithstanding any other provision of this section, the deadlines otherwise established under subsection (d) for the making of determinations in hearings or review under this section shall begin on the date on which the record is complete.

"(D) COMPLETE DESCRIBED.—For purposes of this paragraph, a record is complete when the administrative law judge, in the case of a hearing, or the Departmental Appeals Board, in the case of a review, has received—

"(i) written or testimonial evidence, or both, submitted by the person filing the request,

''(ii) written or oral argument, or both, is presented,

''(iii) the decision of, and the record for, the prior level of appeal,

''(iv) such other evidence as such judge or Board, as the case may be, determines is required to make a determination on the request.''.

(b) USE OF PATIENTS' MEDICAL RECORDS.—Section 1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)) is amended by inserting ''(including the medical records of the individual involved)'' after ''clinical experience''.

(c) NOTICE REQUIREMENTS FOR MEDICARE APPEALS.—

(1) INITIAL DETERMINATIONS AND REDETERMINATIONS.—Section 1869(a) (42 U.S.C. 1395ff(a)) is amended by adding at the end the following new paragraph:

''(4) REQUIREMENTS OF NOTICE OF DETERMINATIONS AND REDETERMINATIONS.—A written notice of a determination on an initial determination or on a redetermination, insofar as such determination or redetermination results in a denial of a claim for benefits, shall be provided in printed form and written in a manner calculated to be understood by the beneficiary and shall include—

''(A) the specific reasons for the determination, including, as appropriate—

''(i) upon request in the case of an initial determination, a summary of the clinical or scientific evidence used in making the determination; and

''(ii) in the case of a redetermination, such a summary;

''(B) the procedures for obtaining additional information concerning the determination or redetermination; and

''(C) notification of the right to seek a redetermination or otherwise appeal the determination and instructions on how to initiate such a redetermination or appeal under this section.''.

(2) RECONSIDERATIONS.—Section 1869(c)(3)(E) (42 U.S.C. 1395ff(c)(3)(E)) is amended—

(A) by inserting ''be written in a manner calculated to be understood by the beneficiary, and shall include (to the extent appropriate)'' after ''in writing, ''; and

(B) by inserting ''and a notification of the right to appeal such determination and instructions on how to initiate such appeal under this section'' after ''such decision, ''.

(3) APPEALS.—Section 1869(d) (42 U.S.C. 1395ff(d)) is amended—

(A) in the heading, by inserting ''; NOTICE'' after ''SECRETARY''; and

(B) by adding at the end the following new paragraph:

''(4) NOTICE.—Notice of the decision of an administrative law judge shall be in writing in a manner calculated to be understood by the beneficiary and shall include—

''(A) the specific reasons for the determination (including, to the extent appropriate, a summary of the clinical or scientific evidence used in making the determination);

''(B) the procedures for obtaining additional information concerning the decision; and

''(C) notification of the right to appeal the decision and instructions on how to initiate such an appeal under this section.''.

(4) PREPARATION OF RECORD FOR APPEAL.—Section 1869(c)(3)(J) (42 U.S.C. 1395ff(c)(3)(J)) by striking ''such information as is required for an appeal'' and inserting ''the record for the appeal''.

(d) QUALIFIED INDEPENDENT CONTRACTORS.—

(1) ELIGIBILITY REQUIREMENTS OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c) (42 U.S.C. 1395ff(c)) is amended—

(A) in paragraph (2)—

(i) by inserting ''(except in the case of a utilization and quality control peer review organization, as defined in section 1152)'' after ''means an entity or organization that''; and

(ii) by striking the period at the end and inserting the following: ''and meets the following requirements:

''(A) GENERAL REQUIREMENTS.—

''(i) The entity or organization has (directly or through contracts or other arrangements) sufficient medical, legal, and other expertise (including knowledge of the program under this title) and sufficient staffing to carry out duties of a qualified independent contractor under this section on a timely basis.

''(ii) The entity or organization has provided assurances that it will conduct activities consistent with the applicable requirements of this section, including that it will not conduct any activities in a case unless the independence requirements of subparagraph (B) are met with respect to the case.

''(iii) The entity or organization meets such other requirements as the Secretary provides by regulation.

''(B) INDEPENDENCE REQUIREMENTS.—

''(i) IN GENERAL.—Subject to clause (ii), an entity or organization meets the independence requirements of this subparagraph with respect to any case if the entity—

''(I) is not a related party (as defined in subsection (g)(5));

''(II) does not have a material familial, financial, or professional relationship with such a party in relation to such case; and

''(III) does not otherwise have a conflict of interest with such a party (as determined under regulations).

"(ii) EXCEPTION FOR REASONABLE COMPENSATION.—Nothing in clause (i) shall be construed to prohibit receipt by a qualified independent contractor of compensation from the Secretary for the conduct of activities under this section if the compensation is provided consistent with clause (iii).

"(iii) LIMITATIONS ON ENTITY COMPENSATION.—Compensation provided by the Secretary to a qualified independent contractor in connection with reviews under this section shall—

"(I) not exceed a reasonable level; and

"(II) not be contingent on any decision rendered by the contractor or by any reviewing professional."; and

(B) in paragraph (3)(A), by striking ", and shall have sufficient training and expertise in medical science and legal matters to make reconsiderations under this subsection".

(2) ELIGIBILITY REQUIREMENTS FOR REVIEWERS.—Section 1869 (42 U.S.C. 1395ff) is amended—

(A) by amending subsection (c)(3)(D) to read as follows:

"(D) QUALIFICATIONS FOR REVIEWERS.—The requirements of subsection (g) shall be met (relating to qualifications of reviewing professionals)."; and

(B) by adding at the end the following new subsection:

"(g) QUALIFICATIONS OF REVIEWERS.—

"(1) IN GENERAL.—In reviewing determinations under this section, a qualified independent contractor shall assure that—

"(A) each individual conducting a review shall meet the qualifications of paragraph (2);

"(B) compensation provided by the contractor to each such reviewer is consistent with paragraph (3); and

"(C) in the case of a review by a panel described in subsection (c)(3)(B) composed of physicians or other health care professionals (each in this subsection referred to as a 'reviewing professional'), each reviewing professional meets the qualifications described in paragraph (4) and, if the request for review indicates that the item or service involved was furnished (or ordered to be furnished) by a physician, each reviewing professional shall be a physician.

"(2) INDEPENDENCE.—

"(A) IN GENERAL.—Subject to subparagraph (B), each individual conducting a review in a case shall—

"(i) not be a related party (as defined in paragraph (5));

"(ii) not have a material familial, financial, or professional relationship with such a party in the case under review; and

"(iii) not otherwise have a conflict of interest with such a party (as determined under regulations).

"(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

"(i) prohibit an individual, solely on the basis of affiliation with a fiscal intermediary, carrier, or other contractor, from serving as an reviewing professional if—

"(I) a non-affiliated individual is not reasonably available;

"(II) the affiliated individual is not involved in the provision of items or services in the case under review;

"(III) the fact of such an affiliation is disclosed to the Secretary and the beneficiary (or authorized representative) and neither party objects; and

"(IV) the affiliated individual is not an employee of the intermediary, carrier, or con-

tractor and does not provide services exclusively or primarily to or on behalf of such intermediary, carrier, or contractor;

"(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as a reviewer merely on the basis of such affiliation if the affiliation is disclosed to the Secretary and the beneficiary (or authorized representative), and neither party objects; or

"(iii) prohibit receipt of compensation by a reviewing professional from a contractor if the compensation is provided consistent with paragraph (3).

"(3) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by a qualified independent contractor to a reviewer in connection with a review under this section shall—

"(A) not exceed a reasonable level; and

"(B) not be contingent on the decision rendered by the reviewer.

"(4) LICENSURE AND EXPERTISE.—Each reviewing professional shall be a physician (allopathic or osteopathic) or health care professional who—

"(A) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

"(B) typically treats the condition, makes the diagnosis, or provides the type of treatment under review.

"(5) RELATED PARTY DEFINED.—For purposes of this section, the term 'related party' means, with respect to a case under this title involving an individual beneficiary, any of the following:

"(A) The Secretary, the medicare administrative contractor involved, or any fiduciary, officer, director, or employee of the Department of Health and Human Services, or of such contractor.

"(B) The individual (or authorized representative).

''(C) The health care professional that provides the items or services involved in the case.

''(D) The institution at which the items or services (or treatment) involved in the case are provided.

''(E) The manufacturer of any drug or other item that is included in the items or services involved in the case.

''(F) Any other party determined under any regulations to have a substantial interest in the case involved.''.

(e) IMPLEMENTATION OF CERTAIN BIPA REFORMS.—

(1) 1-YEAR DELAY IN EFFECTIVE DATES.—(A) Section 521(d) of BIPA (114 Stat. 2763A–543) is amended by striking ''October 1, 2002'' and inserting ''October 1, 2003''.

(B) Section 522(d) of BIPA (114 Stat. 2763A–547) is amended by striking ''October 1, 2001'' and inserting ''October 1, 2002''.

(2) USE OF PEER REVIEW ORGANIZATIONS TO CONDUCT EXPEDITED REVIEW DURING TRANSITION PERIOD.—

(A) IN GENERAL.—Section 1154(e) (42 U.S.C. 1320c–3(e)) is amended by adding at the end the following:

''(6)(A) In applying this subsection during the transition period (described in subparagraph (C)), any reference in this subsection—

''(i) to a hospital is deemed a reference to a provider of services;

''(ii) to inpatient hospital care or services is deemed a reference to services of such a provider of services;

''(iii) a notice under paragraph (1) is deemed to include—

''(I) a notice to discharge the individual from the provider of services; or

''(II) a notice of termination of services by a provider of services, but only in the case in which a physician certifies that failure to continue the provision of

such services is likely to place the individual's health at significant risk; and

"(iv) an inpatient is deemed a reference to a patient.

"(B) After the transition period, paragraphs (2) through (5) shall not apply.

"(C) For purposes of this paragraph and section 1869(b)(1)(F)(ii), the transition period, with respect to an individual who resides in an area served by a peer review organization—

"(i) begins on the date on which the last triennial contract with any peer review organization under this part becomes effective during 2002; and

"(ii) ends on the date that the triennial contract under this part with the organization that serves such area expires in 2006.".

(B) CONFORMING AMENDMENT TO BIPA.—Subsection (c) of section 521 of BIPA is repealed.

(C) CONFORMING AMENDMENT TO SECTION 1869.—Section 1869(b)(1)(F) (42 U.S.C. 1395ff(b)(1)(F)), as amended by section 521 of BIPA, is amended by striking clause (ii) and inserting the following:

"(ii) NO APPLICATION DURING TRANSITION PERIOD.—Clause (i) shall not apply during the transition period described in section 1154(e)(6)(C).".

(D) SECTION 1155 TRANSITION.—Section 1155 (42 U.S.C. 1320c–4) is amended by adding at the end the following: "In the case of a determination made under section 1154(e)(6)(A) during the period in which the provisions of subsection (b) of section 1869 (as added by section 521 of Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, as enacted into law by section 1(a)(6) of Public Law 106–554) are in effect, this section shall not apply but the individual shall be entitled to a hearing on the determination before an administrative law judge under such

subsection (b) in the same manner as such section applies to a hearing under subsection (a) of such section 1869.''.

(f) EFFECTIVE DATE.—The amendments made by this section shall be effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA, 114 Stat. 2763A–534.

(g) TRANSITION.—In applying section 1869(g) of the Social Security Act (as added by subsection (d)(2)), any reference to a medicare administrative contractor shall be deemed to include a reference to a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and a carrier under section 1842 of such Act (42 U.S.C. 1395u).

SEC. 205. HEARING RIGHTS RELATED TO DECISIONS BY THE SECRETARY TO DENY OR NOT RENEW A MEDICARE ENROLLMENT AGREEMENT.

(a) HEARING RIGHTS.—Section 1866 (42 U.S.C. 1395cc) is amended by adding at the end the following new subsection:

''(j) HEARING RIGHTS IN CASES OF DENIAL OR NON-RENEWAL.—A provider of services, physician, practitioner, facility, or supplier whose application to enroll (or, if applicable, to renew enrollment) under this title is denied may have a hearing and judicial review of such denial under the procedures that apply under subsection (h)(1)(A) to a provider of services that is dissatisfied with a determination by the Secretary.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to denials occurring on or after such date (not later than 1 year after the date of the enactment of this Act) as the Secretary specifies.

SEC. 206. APPEALS BY PROVIDERS WHEN THERE IS NO OTHER PARTY AVAILABLE.

(a) IN GENERAL.—Section 1870 (42 U.S.C. 1395gg) is amended by adding at the end the following new subsection:

''(h) Notwithstanding subsection (f) or any other provision of law, the Secretary shall permit a provider of services, physician, practitioner, facility, or supplier to appeal any determination of the Secretary under this title relating to services ren-

dered under this title to an individual who subsequently dies, if there is no other party available to appeal such determination, so long as the estate of the individual, and the individual's family and heirs, are not liable for paying for the item or service and are not liable for any increased coinsurance or deductible amounts resulting from any decision increasing the reimbursement amount for the provider of services, physician, practitioner, facility, or supplier.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act and shall apply to items and services furnished on or after such date.

SEC. 207. PROCESS FOR EXCEPTIONS TO NATIONAL COVERAGE DETERMINATIONS UNDER SPECIAL MEDICAL CIRCUMSTANCES.

(a) IN GENERAL.—Section 1869(f) (42 U.S.C. 1395ff(f)), as added by section 522 of BIPA, is amended—

(1) by redesignating paragraphs (6) through (8) as paragraphs (7) through (9); and

(2) by inserting after paragraph (5) the following new paragraph:

''(6) PROCESS FOR EXCEPTIONS TO NATIONAL COVERAGE DETERMINATIONS UNDER SPECIAL MEDICAL CIRCUMSTANCES.—

''(A) ESTABLISHMENT OF PROCESS.—The Secretary shall establish a process whereby an individual described in paragraph (5) may submit to the Secretary a request for a determination that a national coverage determination, which has the effect of denying coverage under this title for items and services for the treatment of a serious or life-threatening condition of the individual, should not apply to the individual due to the special medical circumstances of the individual that involve medical factors that were not considered during the national coverage determination decision-making procedure and make the application of the national coverage determination inappropriate for the in-

dividual's particular case. Such request shall be accompanied by supporting documentation and may be made before the receipt of the items or services involved.

"(B) USE OF PANEL.—Under such process, the Secretary shall provide that—

"(i) the initial decision on the request is made by a panel described in subparagraph (C); or

"(ii) the individual is provided the opportunity to appeal the initial decision on the request to such a panel.

"(C) PANEL.—A panel described in this subparagraph is a panel of physicians or other appropriate health care professionals in which each member of the panel meets the requirements of paragraphs (2) and (4) of subsection (g) (relating to independence and licensure and expertise).

"(D) APPEAL.—A decision on a request under this paragraph shall be subject to further review (after any appeal described in subparagraph (B)(ii)) by the Departmental Appeals Board and to judicial review, in the same manner as provided under subsection (b) with respect to review of a final decision of the Secretary.

"(E) EXPEDITION.—The process under this paragraph shall provide for reasonable expedition for making decisions on requests when the need for expedition is certified by a physician.

"(F) EFFECT OF DECISION.—If a request under this paragraph is approved for an individual with respect to a treatment, the national coverage determination shall not be applied by any medicare administrative contractor with respect to the treatment for that individual.

"(G) NOTICE.—The Secretary shall provide, in an appropriate annual publication available to the public, a list of national coverage determinations and information on how to get more information with respect to such determinations, made in the previous year.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply as if included in the enactment of section 522 of BIPA.

SEC. 208. PRIOR DETERMINATION PROCESS FOR CERTAIN ITEMS AND SERVICES.

(a) IN GENERAL.—Section 1869 (42 U.S.C. 1395ff(b)), as amended by sections 521 and 522 of BIPA and section 204(d)(2)(B), is further amended by adding at the end the following new subsection:

"(h) PRIOR DETERMINATION PROCESS FOR CERTAIN ITEMS AND SERVICES.—

"(1) ESTABLISHMENT OF PROCESS.—

"(A) IN GENERAL.—With respect to a medicare administrative contractor that has a contract under section 1874A that provides for making payments under this title with respect to items and services, the Secretary shall establish a prior determination process that meets the requirements of this subsection and that shall be applied by such contractor in the case of eligible requesters.

"(B) ELIGIBLE REQUESTER.—For purposes of this subsection, the term 'eligible requester' means—

"(i) a physician, but only in the case of items and services that may be furnished (or ordered to be furnished) by the physician; and

"(ii) an individual entitled to benefits under this title, but only with respect to an item or service for which the individual receives an advance beneficiary notice from the provider or supplier of the item or service under section 1879 that payment may not be made (or may no longer be made) for the item or service under this title.

"(2) ESTABLISHING ELIGIBLE CATEGORIES.—The Secretary shall establish by regulation limits on the categories of items and services for which a prior determination of coverage may be requested under this subsection. In establishing such limits, the Secretary may consider the

dollar amount involved with respect to the item or service, administrative costs and burdens, and other relevant factors.

"(3) REQUEST FOR PRIOR DETERMINATION.—

"(A) IN GENERAL.—Subject to paragraph (2), under the process established under this subsection any eligible requester may submit to the contractor a request for a determination, before the furnishing (or ordering the furnishing) of the item or service involved as to whether the item or service is covered under this title consistent with the applicable requirements of section 1862(a) (relating to medical necessity, etc.).

"(B) ACCOMPANYING DOCUMENTATION.—The request shall be accompanied by a description of the item or service, its billing code (as appropriate), supporting documentation relating to the medical necessity for the item or service, and any other appropriate documentation that the Secretary may require. In the case of a request submitted by an eligible requester that is described in paragraph (1)(B)(ii), the request shall also be accompanied by a copy of the advance beneficiary notice involved.

"(4) RESPONSE TO REQUEST.—

"(A) IN GENERAL.—Under such process, the contractor shall provide the eligible requester with written notice of a determination as to whether—

"(i) the item or service is so covered;

"(ii) the item or service is not so covered; or

"(iii) the contractor lacks sufficient information to make a coverage determination.

In the case of a request in which an eligible requester is not the beneficiary described in paragraph (1)(B)(i), the process shall provide that the beneficiary involved shall be informed of any determination described in clause (ii) (relating to a determination of non-coverage).

"(B) DEADLINE TO RESPOND.—Such notice shall be provided within the same time period as the time period applicable to the contractor providing notice of initial determinations on a claim for benefits under subsection (a)(2)(A).

"(5) EFFECT OF DETERMINATIONS.—

"(A) BINDING NATURE OF POSITIVE DETERMINATION.—If the contractor makes the determination described in paragraph (4)(A)(i), such determination shall be binding on the contractor in the absence of fraud or evidence of misrepresentation of facts presented to the contractor.

"(B) RIGHT TO REDETERMINATION IN CASE OF A DENIAL.—

"(i) IN GENERAL.—If the contractor makes the determination described in paragraph (4)(A)(ii)—

"(I) the eligible requester has the right to a redetermination by the contractor on the determination that the item or service is not so covered; and

"(II) the contractor shall include in notice under paragraph (4)(A) a brief explanation of the basis for the determination and the right to such a redetermination.

"(ii) DEADLINE FOR REDETERMINATIONS.—The contractor shall complete and provide notice of such redetermination within the same time period as the time period applicable to the contractor providing notice of redeterminations relating to a claim for benefits under subsection (a)(3)(C)(ii).

"(C) DESCRIPTION OF ADDITIONAL INFORMATION REQUIRED.—If the contractor makes the determination described in paragraph (4)(A)(iii), the contractor shall include in the notice under paragraph (4)(A) a description of the additional information required to make the coverage determination.

"(6) LIMITATION ON FURTHER REVIEW.—

"(A) IN GENERAL.—Contractor determinations described in paragraph (4)(A)(ii) or (4)(A)(iii) (and redeterminations made under paragraph (5)(B)), relating to pre-service claims are not subject to further administrative appeal or judicial review under this section or otherwise.

"(B) CONSTRUCTION.—Nothing in this subsection shall be construed as affecting the right of an individual, after receiving items or services for which the contractor has made a determination described in paragraph (4)(A)(ii), from submitting a claim for such item or service or from obtaining administrative or judicial review respecting such claim under the other applicable provisions of this section.".

(b) EFFECTIVE DATE; TRANSITION.—

(1) EFFECTIVE DATE.—The Secretary shall establish the prior determination process under the amendment made by subsection (a) in such a manner as to provide for the acceptance of requests for determinations under such process filed not later than 18 months after the date of the enactment of this Act.

(2) TRANSITION.—During the period in which the amendment made by subsection (a) has become effective but contracts are not provided under section 1874A of the Social Security Act with medicare administrative contractors, any reference in section 1869(g) of such Act (as added by such amendment) to such a contractor is deemed a reference to a fiscal intermediary or carrier with an agreement under section 1816, or contract under section 1842, respectively, of such Act.

(c) PROVISIONS RELATING TO ADVANCE BENEFICIARY NOTICES.—

(1) DATA COLLECTION.—The Secretary shall establish a process for the collection of information on the instances in which an advance beneficiary notice (as defined in paragraph (4)) has been provided and on instances in which a

beneficiary indicates on such a notice that the beneficiary does not intend to seek to have the item or service that is the subject of the notice furnished.

(2) OUTREACH AND EDUCATION.—The Secretary shall establish a program of outreach and education for beneficiaries and providers of services and other persons on the appropriate use of advance beneficiary notices and coverage and coverage policies under the medicare program.

(3) GAO REPORT.—Not later than 18 months after the date on which section 1869(g) of the Social Security Act (as added by subsection (a)) takes effect, the Comptroller General of the United States shall submit to Congress a report on the use of advance beneficiary notices under title XVIII of such Act. Such report shall include information concerning the providers of services and other persons that have provided such notices and the response of beneficiaries to such notices, including the use of the prior determination process under such section 1869(g) and their receipt of services.

(4) ADVANCE BENEFICIARY NOTICE DEFINED.—In this subsection, the term ''advance beneficiary notice'' means a written notice provided under section 1879 of the Social Security Act (42 U.S.C. 1395pp) to an individual entitled to benefits under part A or B of title XVIII of such Act before items or services are furnished under such part in cases where a provider of services or other person that would furnish the item or service believes that payment will not be made for some or all of such items or services under such title on the basis that they are not reasonable and necessary consistent with the applicable requirements of section 1862(a) (relating to medical necessity, etc.) of such title.

SEC. 209. BIPA-RELATED TECHNICAL AMENDMENTS AND CORRECTIONS.

(a) TECHNICAL AMENDMENTS RELATING TO ADVISORY COMMITTEE UNDER BIPA SECTION 522.—(1) Subsection (i) of section 1114 (42 U.S.C. 1314)—

(A) is transferred to section 1862 and added at the end of such section; and

(B) is redesignated as subsection (j).

(2) Section 1862 (42 U.S.C. 1395y) is amended—

(A) in the last sentence of subsection (a), by striking ''section 1114(f)'' and inserting ''section 222 of the Public Health Service Act''; and

(B) in subsection (j), as so transferred and redesignated—

(i) by striking ''subsection (f)'' and inserting ''section 222 of the Public Health Service Act'';

(ii) by striking ''section 1862(a)(1)'' and inserting ''subsection (a)(1)''.

(b) TERMINOLOGY CORRECTIONS.—(1) Section 1869(c)(3)(I)(ii) (42 U.S.C. 1395ff(c)(3)(I)(ii)), as amended by section 521 of BIPA, is amended—

(A) in subclause (III), by striking ''policy'' and inserting ''determination''; and

(B) in subclause (IV), by striking ''medical review policies'' and inserting ''coverage determinations''.

(2) Section 1852(a)(2)(C) (42 U.S.C. 1395w–22(a)(2)(C)) is amended by striking ''policy'' and inserting ''determination'' both places it appears.

(c) REFERENCE CORRECTIONS.—Section 1869(f)(4) (42 U.S.C. 1395ff(f)(4)), as added by section 522 of BIPA, is amended—

(1) in subparagraph (A)(iv), by striking ''subclause (I), (II), or (III)'' and inserting ''clause (i), (ii), or (iii)'';

(2) in subparagraph (B), by striking ''clause (i)(IV)'' and ''clause (i)(III)'' and inserting ''subparagraph (A)(iv)'' and ''subparagraph (A)(iii)'', respectively; and

(3) in subparagraph (C), by striking ''clause (i)'', ''subclause (IV)'' and ''subparagraph (A)'' and inserting ''subparagraph (A)'', ''clause (iv)'' and ''paragraph (1)(A)'', respectively each place it appears.

(d) EFFECTIVE DATE.—The amendments made by this section shall be effective as if included in the enactment of BIPA.

TITLE III—CONTRACTING REFORM

SEC. 301. INCREASED FLEXIBILITY IN MEDICARE ADMINISTRATION.

(a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE ADMINISTRATION.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1874 the following new section:

''CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS

''SEC. 1874A. (a) AUTHORITY.—

''(1) AUTHORITY TO ENTER INTO CONTRACTS.—The Secretary may enter into contracts with any eligible entity to serve as a medicare administrative contractor with respect to the performance of any or all of the functions described in paragraph (4) or parts of those functions (or, to the extent provided in a contract, to secure performance thereof by other entities).

''(2) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract with respect to the performance of a particular function or activity described in paragraph (4) only if—

''(A) the entity has demonstrated capability to carry out such function;

''(B) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement;

''(C) the entity has sufficient assets to financially support the performance of such function; and

''(D) the entity meets such other requirements as the Secretary may impose.

''(3) MEDICARE ADMINISTRATIVE CONTRACTOR DEFINED.—For purposes of this title and title XI—

''(A) IN GENERAL.—The term 'medicare administrative contractor' means an agency, organization, or other person with a contract under this section.

"(B) APPROPRIATE MEDICARE ADMINISTRATIVE CONTRACTOR.—With respect to the performance of a particular function or activity in relation to an individual entitled to benefits under part A or enrolled under part B, or both, a specific provider of services, physician, practitioner, facility, or supplier (or class of such providers of services, physicians, practitioners, facilities, or suppliers), the 'appropriate' medicare administrative contractor is the medicare administrative contractor that has a contract under this section with respect to the performance of that function or activity in relation to that individual, provider of services, physician, practitioner, facility, or supplier or class of provider of services, physician, practitioner, facility, or supplier.

"(4) FUNCTIONS DESCRIBED.—The functions referred to in paragraphs (1) and (2) are payment functions, provider services functions, and beneficiary services functions as follows:

"(A) DETERMINATION OF PAYMENT AMOUNTS.—Determining (subject to the provisions of section 1878 and to such review by the Secretary as may be provided for by the contracts) the amount of the payments required pursuant to this title to be made to providers of services, physicians, practitioners, facilities, suppliers, and individuals.

"(B) MAKING PAYMENTS.—Making payments described in subparagraph (A) (including receipt, disbursement, and accounting for funds in making such payments).

"(C) BENEFICIARY EDUCATION AND ASSISTANCE.—Serving as a center for, and communicating to individuals entitled to benefits under part A or enrolled under part B, or both, with respect to education and outreach for those individuals, and assistance with specific issues, concerns or problems of those individuals.

"(D) PROVIDER CONSULTATIVE SERVICES.—Providing consultative services to institutions, agencies, and other persons to enable them to establish and maintain fiscal records necessary for purposes of this title and otherwise to qualify as providers of services, physicians, practitioners, facilities, or suppliers.

"(E) COMMUNICATION WITH PROVIDERS.—Serving as a center for, and communicating to providers of services, physicians, practitioners, facilities, and suppliers, any information or instructions furnished to the medicare administrative contractor by the Secretary, and serving as a channel of communication from such providers, physicians, practitioners, facilities, and suppliers to the Secretary.

"(F) PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.—Performing the functions described in subsections (e) and (f), relating to education, training, and technical assistance to providers of services, physicians, practitioners, facilities, and suppliers.

"(G) ADDITIONAL FUNCTIONS.—Performing such other functions as are necessary to carry out the purposes of this title.

"(5) RELATIONSHIP TO MIP CONTRACTS.—

"(A) NONDUPLICATION OF DUTIES.—In entering into contracts under this section, the Secretary shall assure that functions of medicare administrative contractors in carrying out activities under parts A and B do not duplicate functions carried out under the Medicare Integrity Program under section 1893. The previous sentence shall not apply with respect to the activity described in section 1893(b)(5) (relating to prior authorization of certain items of durable medical equipment under section 1834(a)(15)).

"(B) CONSTRUCTION.—An entity shall not be treated as a medicare administrative contractor merely by reason of having entered into a contract with the Secretary under section 1893.

"(6) APPLICATION OF FEDERAL ACQUISITION REGULATION.—Except to the extent inconsistent with a specific requirement of this title, the Federal Acquisition Regulation applies to contracts under this title.

"(b) CONTRACTING REQUIREMENTS.—

"(1) USE OF COMPETITIVE PROCEDURES.—

"(A) IN GENERAL.—Except as provided in laws with general applicability to Federal acquisition and procurement or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts with medicare administrative contractors under this section.

"(B) RENEWAL OF CONTRACTS.—The Secretary may renew a contract with a medicare administrative contractor under this section from term to term without regard to section 5 of title 41, United States Code, or any other provision of law requiring competition, if the medicare administrative contractor has met or exceeded the performance requirements applicable with respect to the contract and contractor, except that the Secretary shall provide for the application of competitive procedures under such a contract not less frequently than once every five years.

"(C) TRANSFER OF FUNCTIONS.—The Secretary may transfer functions among medicare administrative contractors without regard to any provision of law requiring competition. The Secretary shall ensure that performance quality is considered in such transfers. The Secretary shall provide notice (whether in the Federal Register or otherwise) of any such transfer (including a description of the functions so transferred and contact information for the contractors involved) to providers of services, physicians, practitioners, facilities, and suppliers affected by the transfer.

"(D) INCENTIVES FOR QUALITY.—The Secretary shall provide incentives for medicare administrative

contractors to provide quality service and to promote efficiency.

''(2) COMPLIANCE WITH REQUIREMENTS.—No contract under this section shall be entered into with any medicare administrative contractor unless the Secretary finds that such medicare administrative contractor will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as the Secretary finds pertinent.

''(3) PERFORMANCE REQUIREMENTS.—

''(A) DEVELOPMENT OF SPECIFIC PERFORMANCE REQUIREMENTS.—The Secretary shall develop contract performance requirements to carry out the specific requirements applicable under this title to a function described in subsection (a)(4) and shall develop standards for measuring the extent to which a contractor has met such requirements. The Secretary shall publish in the Federal Register such performance requirements and measurement standards.

''(B) CONSIDERATIONS.—The Secretary may include as one of the standards satisfaction level as measured by provider and beneficiary surveys.

''(C) INCLUSION IN CONTRACTS.—All contractor performance requirements shall be set forth in the contract between the Secretary and the appropriate medicare administrative contractor. Such performance requirements—

''(i) shall reflect the performance requirements published under subparagraph (A), but may include additional performance requirements;

''(ii) shall be used for evaluating contractor performance under the contract; and

''(iii) shall be consistent with the written statement of work provided under the contract.

''(4) INFORMATION REQUIREMENTS.—The Secretary shall not enter into a contract with a medicare administra-

tive contractor under this section unless the contractor agrees—

"(A) to furnish to the Secretary such timely information and reports as the Secretary may find necessary in performing his functions under this title; and

"(B) to maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (A) and otherwise to carry out the purposes of this title.

"(5) SURETY BOND.—A contract with a medicare administrative contractor under this section may require the medicare administrative contractor, and any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

"(c) TERMS AND CONDITIONS.—

"(1) IN GENERAL.—A contract with any medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the medicare administrative contractor for the making of payments by it under subsection (a)(4)(B).

"(2) PROHIBITION ON MANDATES FOR CERTAIN DATA COLLECTION.—The Secretary may not require, as a condition of entering into, or renewing, a contract under this section, that the medicare administrative contractor match data obtained other than in its activities under this title with data used in the administration of this title for purposes of identifying situations in which the provisions of section 1862(b) may apply.

"(d) LIMITATION ON LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTORS AND CERTAIN OFFICERS.—

"(1) CERTIFYING OFFICER.—No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of gross negligence or intent to

defraud the United States, be liable with respect to any payments certified by the individual under this section.

"(2) DISBURSING OFFICER.—No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by such officer under this section if it was based upon an authorization (which meets the applicable requirements for such internal controls established by the Comptroller General) of a certifying officer designated as provided in paragraph (1) of this subsection.

"(3) LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTOR.—No medicare administrative contractor shall be liable to the United States for a payment by a certifying or disbursing officer unless in connection with such payment or in the supervision of or selection of such officer the medicare administrative contractor acted with gross negligence.

"(4) LIMITATION ON CIVIL LIABILITY.—

"(A) IN GENERAL.—No medicare administrative contractor having a contract with the Secretary under this section, and no person employed by, or having a fiduciary relationship with, any such medicare administrative contractor or who furnishes professional services to such medicare administrative contractor, shall by reason of the performance of any duty, function, or activity required or authorized pursuant to this section or to a valid contract entered into under this section, be held civilly liable under any law of the United States or of any State (or political subdivision thereof) provided due care was exercised in the performance of such duty, function, or activity.

"(B) REIMBURSEMENT OF CERTAIN EXPENSES.—The Secretary shall make payment to a medicare administrative contractor under contract with the Secretary pursuant to this section, or to any member or employee thereof, or to any person who furnishes legal counsel or services to such medicare administrative con-

tractor, in an amount equal to the reasonable amount of the expenses incurred, as determined by the Secretary, in connection with the defense of any civil suit, action, or proceeding brought against such medicare administrative contractor or person related to the performance of any duty, function, or activity under such contract, provided due care was exercised in the performance of such duty, function, or activity.''.

(2) CONSIDERATION OF INCORPORATION OF CURRENT LAW STANDARDS.—In developing contract performance requirements under section 1874A(b) of the Social Security Act, as inserted by paragraph (1), the Secretary shall consider inclusion of the performance standards described in sections 1816(f)(2) of such Act (relating to timely processing of reconsiderations and applications for exemptions) and section 1842(b)(2)(B) of such Act (relating to timely review of determinations and fair hearing requests), as such sections were in effect before the date of the enactment of this Act.

(b) CONFORMING AMENDMENTS TO SECTION 1816 (RELATING TO FISCAL INTERMEDIARIES).—Section 1816 (42 U.S.C. 1395h) is amended as follows:

(1) The heading is amended to read as follows:

''PROVISIONS RELATING TO THE ADMINISTRATION OF PART A''.

(2) Subsection (a) is amended to read as follows:

''(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.''.

(3) Subsection (b) is repealed.

(4) Subsection (c) is amended—

(A) by striking paragraph (1); and

(B) in each of paragraphs (2)(A) and (3)(A), by striking ''agreement under this section'' and inserting ''contract under section 1874A that provides for making payments under this part''.

(5) Subsections (d) through (i) are repealed.

(6) Subsections (j) and (k) are each amended—

(A) by striking ''An agreement with an agency or organization under this section'' and inserting ''A contract with a medicare administrative contractor under section 1874A with respect to the administration of this part''; and

(B) by striking ''such agency or organization'' and inserting ''such medicare administrative contractor'' each place it appears.

(7) Subsection (l) is repealed.

(c) CONFORMING AMENDMENTS TO SECTION 1842 (RELATING TO CARRIERS).—Section 1842 (42 U.S.C. 1395u) is amended as follows:

(1) The heading is amended to read as follows:

''PROVISIONS RELATING TO THE ADMINISTRATION OF PART B''.

(2) Subsection (a) is amended to read as follows:

''(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.''.

(3) Subsection (b) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2)—

(i) by striking subparagraphs (A) and (B);

(ii) in subparagraph (C), by striking ''carriers'' and inserting ''medicare administrative contractors''; and

(iii) by striking subparagraphs (D) and (E);

(C) in paragraph (3)—

(i) in the matter before subparagraph (A), by striking ''Each such contract shall provide that the carrier'' and inserting ''The Secretary'';

(ii) by striking ''will'' the first place it appears in each of subparagraphs (A), (B), (F), (G), (H), and (L) and inserting ''shall'';

(iii) in subparagraph (B), in the matter before clause (i), by striking ''to the policyholders and subscribers of the carrier'' and inserting ''to the

policyholders and subscribers of the medicare administrative contractor'';

(iv) by striking subparagraphs (C), (D), and (E);

(v) in subparagraph (H)—

(I) by striking ''if it makes determinations or payments with respect to physicians' services,''; and

(II) by striking ''carrier'' and inserting ''medicare administrative contractor'';

(vi) by striking subparagraph (I);

(vii) in subparagraph (L), by striking the semicolon and inserting a period;

(viii) in the first sentence, after subparagraph (L), by striking ''and shall contain'' and all that follows through the period; and

(ix) in the seventh sentence, by inserting ''medicare administrative contractor,'' after ''carrier,''; and

(D) by striking paragraph (5);

(E) in paragraph (6)(D)(iv), by striking ''carrier'' and inserting ''medicare administrative contractor''; and

(F) in paragraph (7), by striking ''the carrier'' and inserting ''the Secretary'' each place it appears.

(4) Subsection (c) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2), by striking ''contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B),'' and inserting ''contract under section 1874A that provides for making payments under this part'';

(C) in paragraph (3)(A), by striking ''subsection (a)(1)(B)'' and inserting ''section 1874A(a)(3)(B)'';

(D) in paragraph (4), by striking ''carrier'' and inserting ''medicare administrative contractor'';

(E) in paragraph (5), by striking ''contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), shall require the carrier'' and ''carrier responses'' and inserting ''contract under section 1874A that provides for making payments under this part shall require the medicare administrative contractor'' and ''contractor responses'', respectively; and

(F) by striking paragraph (6).

(5) Subsections (d), (e), and (f) are repealed.

(6) Subsection (g) is amended by striking ''carrier or carriers'' and inserting ''medicare administrative contractor or contractors''.

(7) Subsection (h) is amended—

(A) in paragraph (2)—

(i) by striking ''Each carrier having an agreement with the Secretary under subsection (a)'' and inserting ''The Secretary''; and

(ii) by striking ''Each such carrier'' and inserting ''The Secretary'';

(B) in paragraph (3)(A)—

(i) by striking ''a carrier having an agreement with the Secretary under subsection (a)'' and inserting ''medicare administrative contractor having a contract under section 1874A that provides for making payments under this part''; and

(ii) by striking ''such carrier'' and inserting ''such contractor'';

(C) in paragraph (3)(B)—

(i) by striking ''a carrier'' and inserting ''a medicare administrative contractor'' each place it appears; and

(ii) by striking ''the carrier'' and inserting ''the contractor'' each place it appears; and

(D) in paragraphs (5)(A) and (5)(B)(iii), by striking ''carriers'' and inserting ''medicare administrative contractors'' each place it appears.

(8) Subsection (l) is amended—

(A) in paragraph (1)(A)(iii), by striking ''carrier'' and inserting ''medicare administrative contractor''; and

(B) in paragraph (2), by striking ''carrier'' and inserting ''medicare administrative contractor''.

(9) Subsection (p)(3)(A) is amended by striking ''carrier'' and inserting ''medicare administrative contractor''.

(10) Subsection (q)(1)(A) is amended by striking ''carrier''.

(d) EFFECTIVE DATE; TRANSITION RULE.—

(1) EFFECTIVE DATE.—

(A) APPLICATION TO COMPETITIVELY BID CONTRACTS.—The amendments made by this section shall apply to contracts that are competitively bid on or after such date or dates (but not later than 2 years after the date of the enactment of this Act) as the Secretary specifies.

(B) CONSTRUCTION FOR CURRENT CONTRACTS.—Such amendments shall not apply to contracts in effect before the date specified under subparagraph (A) that continue to retain the terms and conditions in effect on such date until such date as the contract is let out for competitive bidding under such amendments.

(C) DEADLINE FOR COMPETITIVE BIDDING.—The Secretary shall provide for the letting by competitive bidding of all contracts for functions of medicare administrative contractors for annual contract periods that begin on or after October 1, 2008.

(2) GENERAL TRANSITION RULES.—The Secretary shall take such steps, consistent with paragraph (1)(B) and (1)(C), as are necessary to provide for an appropriate transition from contracts under section 1816 and section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u) to contracts under section 1874A, as added by subsection (a)(1).

(3) AUTHORIZING CONTINUATION OF MIP FUNCTIONS UNDER CURRENT CONTRACTS AND AGREEMENTS AND UNDER ROLLOVER CONTRACTS.—The provisions contained in the exception in section 1893(d)(2) of the Social Security Act (42 U.S.C. 1395ddd(d)(2)) shall continue to apply notwithstanding the amendments made by this section, and any reference in such provisions to an agreement or contract shall be deemed to include a contract under section 1874A of such Act, as inserted by subsection (a)(1), that continues the activities referred to in such provisions.

(e) REFERENCES.—On and after the effective date provided under subsection (d)(1), any reference to a fiscal intermediary or carrier under title XI or XVIII of the Social Security Act (or any regulation, manual instruction, interpretative rule, statement of policy, or guideline issued to carry out such titles) shall be deemed a reference to an appropriate medicare administrative contractor (as provided under section 1874A of the Social Security Act).

(f) SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of the enactment of this Act, the Secretary shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this section.

(g) REPORTS ON IMPLEMENTATION.—

(1) PROPOSAL FOR IMPLEMENTATION.—At least 1 year before the date the Secretary proposes to first implement the plan for implementation of the amendments made by this section, the Secretary shall submit a report to Congress and the Comptroller General of the United States that describes such plan. The Comptroller General shall conduct an evaluation of such plan and shall submit to Congress, not later than 6 months after the date the report is received, a report on such evaluation and shall include in such report such recommendations as the Comptroller General deems appropriate.

(2) STATUS OF IMPLEMENTATION.—The Secretary shall submit a report to Congress not later than October 1, 2006, that describes the status of implementation of such amendments and that includes a description of the following:

(A) The number of contracts that have been competitively bid as of such date.

(B) The distribution of functions among contracts and contractors.

(C) A timeline for complete transition to full competition.

(D) A detailed description of how the Secretary has modified oversight and management of medicare contractors to adapt to full competition.

SEC. 302. REQUIREMENTS FOR INFORMATION SECURITY.

(a) IN GENERAL.—Section 1874A, as added by section 301, is amended by adding at the end the following new subsection:

''(e) REQUIREMENTS FOR INFORMATION SECURITY.—

''(1) DEVELOPMENT OF INFORMATION SECURITY PROGRAM.—A medicare administrative contractor that performs the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) shall implement a contractor-wide information security program to provide information security for the operation and assets of the contractor with respect to such functions under this title. An information security program under this paragraph shall meet the requirements for information security programs imposed on Federal agencies under section 3534(b)(2) of title 44, United States Code (other than requirements under subparagraphs (B)(ii), (F)(iii), and (F)(iv) of such section).

''(2) INDEPENDENT AUDITS.—

''(A) PERFORMANCE OF ANNUAL EVALUATIONS.—Each year a medicare administrative contractor that performs the functions referred to in subparagraphs

(A) and (B) of subsection (a)(4) (relating to determining and making payments) shall undergo an evaluation of the information security of the contractor with respect to such functions under this title. The evaluation shall—

"(i) be performed by an entity that meets such requirements for independence as the Inspector General of the Department of Health and Human Services may establish; and

"(ii) test the effectiveness of information security control techniques for an appropriate subset of the contractor's information systems (as defined in section 3502(8) of title 44, United States Code) relating to such functions under this title and an assessment of compliance with the requirements of this subsection and related information security policies, procedures, standards and guidelines.

"(B) DEADLINE FOR INITIAL EVALUATION.—

"(i) NEW CONTRACTORS.—In the case of a medicare administrative contractor covered by this subsection that has not previously performed the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) as a fiscal intermediary or carrier under section 1816 or 1842, the first independent evaluation conducted pursuant subparagraph (A) shall be completed prior to commencing such functions.

"(ii) OTHER CONTRACTORS.—In the case of a medicare administrative contractor covered by this subsection that is not described in clause (i), the first independent evaluation conducted pursuant subparagraph (A) shall be completed within 1 year after the date the contractor commences functions referred to in clause (i) under this section.

"(C) REPORTS ON EVALUATIONS.—

"(i) TO THE INSPECTOR GENERAL.—The results of independent evaluations under subparagraph (A) shall be submitted promptly to the Inspector General of the Department of Health and Human Services.

"(ii) TO CONGRESS.—The Inspector General of Department of Health and Human Services shall submit to Congress annual reports on the results of such evaluations.".

(b) APPLICATION OF REQUIREMENTS TO FISCAL INTERMEDIARIES AND CARRIERS.—

(1) IN GENERAL.—The provisions of section 1874A(e)(2) of the Social Security Act (other than subparagraph (B)), as added by subsection (a), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

(2) DEADLINE FOR INITIAL EVALUATION.—In the case of such a fiscal intermediary or carrier with an agreement or contract under such respective section in effect as of the date of the enactment of this Act, the first evaluation under section 1874A(e)(2)(A) of the Social Security Act (as added by subsection (a)), pursuant to paragraph (1), shall be completed (and a report on the evaluation submitted to the Secretary) by not later than 1 year after such date.

TITLE IV—EDUCATION AND OUTREACH IMPROVEMENTS

SEC. 401. PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.

(a) COORDINATION OF EDUCATION FUNDING.—

(1) IN GENERAL.—The Social Security Act is amended by inserting after section 1888 the following new section:

''PROVIDER EDUCATION AND TECHNICAL ASSISTANCE

''SEC. 1889. (a) COORDINATION OF EDUCATION FUNDING.—The Secretary shall coordinate the educational activities provided through medicare contractors (as defined in subsection (f), including under section 1893) in order to maximize the effectiveness of Federal education efforts for providers of services, physicians, practitioners, facilities, and suppliers.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

(3) REPORT.—Not later than October 1, 2002, the Secretary shall submit to Congress a report that includes a description and evaluation of the steps taken to coordinate the funding of provider education under section 1889(a) of the Social Security Act, as added by paragraph (1).

(b) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE.—

(1) IN GENERAL.—Section 1874A, as added by section 301(a)(1) and as amended by section 302, is amended by adding at the end the following new subsection:

''(f) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE IN PROVIDER EDUCATION AND OUTREACH.—In order to give medicare administrative contractors an incentive to implement effective education and outreach programs for providers of services, physicians, practitioners, facilities, and suppliers, the Secretary shall implement, a methodology to measure the specific claims payment error rates of such contractors in the processing or reviewing of medicare claims.''.

(2) APPLICATION TO FISCAL INTERMEDIARIES AND CARRIERS.—The provisions of section 1874A(f) of the Social Security Act, as added by paragraph (1), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

(3) REPORTS.—Not later than October 1, 2002—

(A) the Secretary shall submit to Congress a report that describes how the Secretary intends to use the methodology in assessing medicare contractor performance in implementing effective education and outreach programs, including whether to use such methodology as a basis for performance bonuses; and

(B) the Comptroller General of the United States shall submit to Congress and to the Secretary a report on the adequacy of such methodology and shall include in the report such recommendations as the Comptroller General determines appropriate with respect to the methodology.

(c) REQUIREMENT TO MAINTAIN INTERNET SITES.—

(1) IN GENERAL.—Section 1889, as added by subsection (a), is amended by adding at the end the following new subsection:

''(b) INTERNET SITES; FAQS.—The Secretary, and each medicare contractor insofar as it provides services (including claims processing) for providers of services, physicians, practitioners, facilities, or suppliers, shall maintain an Internet site which—

''(1) provides answers in an easily accessible format to frequently asked questions, and

''(2) includes all materials published by the Secretary or the contractor, respectively,

relating to such providers of services, physicians, practitioners, facilities, and suppliers under the programs under this title and title XI insofar as it relates to such programs.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2002.

(d) IMPROVED PROVIDER EDUCATION AND TRAINING.—

(1) INCREASED FUNDING FOR ENHANCED EDUCATION AND TRAINING THROUGH MEDICARE INTEGRITY PROGRAM.—Section 1817(k)(4) (42 U.S.C. 1395i(k)(4)) is amended—

(A) in subparagraph (A), by striking '', subject to subparagraph (B)'' and inserting ''and functions described in subparagraph (C)(ii), subject to subparagraphs (B) and (C)'';

(B) in subparagraph (B), by striking ''The amount appropriated'' and inserting ''Subject to subparagraph (C), the amount appropriated''; and

(C) by adding at the end the following new subparagraph:

''(C) ENHANCED PROVIDER EDUCATION AND TRAINING.—

''(i) IN GENERAL.—In addition to the amount appropriated under subparagraph (B), the amount appropriated under subparagraph (A) for a fiscal year (beginning with fiscal year 2003) is increased by $35,000,000.

''(ii) USE.—The funds made available under this subparagraph shall be used only to increase the conduct by medicare contractors of education and training of providers of services, physicians, practitioners, facilities, and suppliers regarding billing, coding, and other appropriate items and may also be used to improve the accuracy, consistency, and timeliness of contractor responses to written and phone inquiries from providers of services, physicians, practitioners, facilities, and suppliers.''.

(2) TAILORING EDUCATION AND TRAINING FOR SMALL PROVIDERS OR SUPPLIERS.—

(A) IN GENERAL.—Section 1889, as added by subsection (a) and as amended by subsection (c), is further amended by adding at the end the following new subsection:

''(c) TAILORING EDUCATION AND TRAINING ACTIVITIES FOR SMALL PROVIDERS OR SUPPLIERS.—

''(1) IN GENERAL.—Insofar as a medicare contractor conducts education and training activities, it shall take into consideration the special needs of small providers of serv-

ices or suppliers (as defined in paragraph (2)). Such education and training activities for small providers or services and suppliers may include the provision of technical assistance (such as review of billing systems and internal controls to determine program compliance and to suggest more efficient and effective means of achieving such compliance).

''(2) SMALL PROVIDER OF SERVICES OR SUPPLIER.—In this subsection, the term 'small provider of services or supplier' means—

''(A) an institutional provider of services with fewer than 25 full-time-equivalent employees; or

''(B) a physician, practitioner, facility, or supplier with fewer than 10 full-time-equivalent employees.''.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall take effect on October 1, 2002.

(e) ADDITIONAL PROVIDER EDUCATION PROVISIONS.—

(1) IN GENERAL.—Section 1889, as added by subsection (a) and as amended by subsections (c) and (d)(2), is further amended by adding at the end the following new subsections:

''(d) ENCOURAGEMENT OF PARTICIPATION IN EDUCATION PROGRAM ACTIVITIES.—A medicare contractor may not use a record of attendance at (or failure to attend) educational activities or other information gathered during an educational program conducted under this section or otherwise by the Secretary to select or track providers of services, physicians, practitioners, facilities, or suppliers for the purpose of conducting any type of audit or prepayment review.

''(e) CONSTRUCTION.—Nothing in this section or section 1893(g) shall be construed as providing for disclosure by a medicare contractor of information that would compromise pending law enforcement activities or reveal findings of law enforcement-related audits.

''(f) DEFINITIONS.—For purposes of this section and section 1817(k)(4)(C), the term 'medicare contractor' includes the following:

"(1) A medicare administrative contractor with a contract under section 1874A, a fiscal intermediary with a contract under section 1816, and a carrier with a contract under section 1842.

"(2) An eligible entity with a contract under section 1893.

Such term does not include, with respect to activities of a specific provider of services, physician, practitioner, facility, or supplier an entity that has no authority under this title or title XI with respect to such activities and such provider of services, physician, practitioner, facility, or supplier.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

SEC. 402. ACCESS TO AND PROMPT RESPONSES FROM MEDICARE ADMINISTRATIVE CONTRACTORS.

(a) IN GENERAL.—Section 1874A, as added by section 301 and as amended by sections 302 and 401(b)(1), is further amended by adding at the end the following new subsection:

"(g) COMMUNICATIONS WITH BENEFICIARIES, PROVIDERS OF SERVICES, PHYSICIANS, PRACTITIONERS, FACILITIES, AND SUPPLIERS.—

"(1) COMMUNICATION STRATEGY.—The Secretary shall develop a strategy for communications with beneficiaries and with providers of services, physicians, practitioners, facilities, and suppliers under this title.

"(2) RESPONSE TO WRITTEN INQUIRIES.—Each medicare administrative contractor shall, for those providers of services, physicians, practitioners, facilities, and suppliers which submit claims to the contractor for claims processing and for those beneficiaries with respect to which claims are submitted for claims processing, provide general written responses (which may be through electronic transmission) in a clear, concise, and accurate manner to inquiries by beneficiaries, providers of services, physicians, practitioners, facilities, and suppliers concerning the programs under this

title within 45 business days of the date of receipt of such inquiries.

"(3) RESPONSE TO TOLL-FREE LINES.—Each medicare administrative contractor shall, for those providers of services, physicians, practitioners, facilities, and suppliers which submit claims to the contractor for claims processing and for those beneficiaries with respect to which claims are submitted for claims processing, maintain a toll-free telephone number at which beneficiaries, providers, physicians, practitioners, facilities, and suppliers may obtain information regarding billing, coding, claims, coverage, and other appropriate information under this title.

"(4) MONITORING OF CONTRACTOR RESPONSES.—

"(A) IN GENERAL.—Each medicare administrative contractor shall, consistent with standards developed by the Secretary under subparagraph (B)—

"(i) maintain a system for identifying who provides the information referred to in paragraphs (2) and (3); and

"(ii) monitor the accuracy, consistency, and timeliness of the information so provided.

"(B) DEVELOPMENT OF STANDARDS.—

"(i) IN GENERAL.—The Secretary shall establish (and publish in the Federal Register) standards to monitor the accuracy, consistency, and timeliness of the information provided in response to written and telephone inquiries under this subsection. Such standards shall be consistent with the performance requirements established under subsection (b)(3).

"(ii) EVALUATION.—In conducting evaluations of individual medicare administrative contractors, the Secretary shall take into account the results of the monitoring conducted under subparagraph (A) taking into account as performance requirements the standards established under clause (i).

"(C) DIRECT MONITORING.—Nothing in this paragraph shall be construed as preventing the Secretary from directly monitoring the accuracy, consistency, and timeliness of the information so provided.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect October 1, 2002.

(c) APPLICATION TO FISCAL INTERMEDIARIES AND CARRIERS.—The provisions of section 1874A(g) of the Social Security Act, as added by subsection (a), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

SEC. 403. RELIANCE ON GUIDANCE.

(a) IN GENERAL.—Section 1871(e), as added by section 102(a), is further amended by adding at the end the following new paragraph:

"(2) If—

"(A) a provider of services, physician, practitioner, facility, or supplier follows written guidance (which may have been transmitted electronically) provided—

"(i) by the Secretary; or

"(ii) by a medicare contractor (as defined in section 1889(f) and whether in the form of a written response to a written inquiry under section 1874A(g)(1) or otherwise) acting within the scope of the contractor's contract authority,

in response to a written inquiry with respect to the furnishing of an item or service or the submission of a claim for benefits for such an item or service;

"(B) the Secretary determines that—

"(i) the provider of services, physician, practitioner, facility, or supplier has accurately presented the circumstances relating to such item, service, and claim to the Secretary or the contractor in the written guidance; and

''(ii) there is no indication of fraud or abuse committed by the provider of services, physician, practitioner, facility, or supplier against the program under this title; and

''(C) the guidance was in error;

the provider of services, physician, practitioner, facility, or supplier shall not be subject to any penalty or interest (relating to an overpayment, if any) under this title (or the provisions of title XI insofar as they relate to this title) relating to the provision of such item or service or such claim if the provider of services, physician, practitioner, facility, or supplier reasonably relied on such guidance. In applying this paragraph with respect to guidance in the form of general responses to frequently asked questions, the Secretary retains authority to determine the extent to which such general responses apply to the particular circumstances of individual claims. Nothing in this paragraph shall be construed as affecting the application of section 1870(c) (relating to no adjustment in the cases of certain overpayments).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to penalties imposed on or after the date of the enactment of this Act.

SEC. 404. FACILITATION OF CONSISTENT INFORMATION TO PROVIDERS.

The Secretary shall appoint an individual within the Department of Health and Human Services who shall be responsible—

(1) for responding to complaints and grievances from providers of services, physicians, practitioners, facilities, and suppliers under the medicare program under title XVIII of the Social Security Act (including provisions of title XI of the Social Security Act insofar as they relate to such title XVIII and are not administered by the Office of the Inspector General of the Department of Health and Human Services) concerning inconsistent information or inconsistent responses provided under such program; and

(2) in so responding, for facilitating an appropriate response from the Department of Health and Human Services or from appropriate medicare contractors.

Such individual shall not serve as an advocate for any specific policy within the Department.

SEC. 405. POLICY DEVELOPMENT REGARDING EVALUATION AND MANAGEMENT (E & M) DOCUMENTATION GUIDELINES.

(a) IN GENERAL.—The Secretary may not implement any new documentation guidelines for evaluation and management physician services under the title XVIII of the Social Security Act on or after the date of the enactment of this Act unless the Secretary—

(1) has developed the guidelines in collaboration with practicing physicians (including both generalists and specialists) and provided for an assessment of the proposed guidelines by the physician community;

(2) has established a plan that contains specific goals, including a schedule, for improving the use of such guidelines;

(3) has conducted appropriate and representative pilot projects under subsection (b) to test the evaluation and management documentation guidelines;

(4) finds that the objectives described in subsection (c) will be met in the implementation of such guidelines; and

(5) has established, and is implementing, a program to educate physicians on the use of such guidelines.

The Secretary may make changes to the manner in which existing evaluation and management documentation guidelines are implemented to reduce paperwork burdens on physicians.

(b) PILOT PROJECTS TO TEST EVALUATION AND MANAGEMENT DOCUMENTATION GUIDELINES.—

(1) IN GENERAL.—The Secretary shall conduct under this subsection appropriate and representative pilot projects to test new evaluation and management documentation guidelines referred to in subsection (a).

(2) LENGTH AND CONSULTATION.—Each pilot project under this subsection shall—

(A) be voluntary;

(B) be of sufficient length as determined by the Secretary to allow for preparatory physician and medicare contractor education, analysis, and use and assessment of potential evaluation and management guidelines; and

(C) be conducted, in development and throughout the planning and operational stages of the project, in consultation with practicing physicians (including both generalists and specialists).

(3) RANGE OF PILOT PROJECTS.—Of the pilot projects conducted under this subsection—

(A) at least one shall focus on a peer review method by physicians (not employed by a medicare contractor) which evaluates medical record information for claims submitted by physicians identified as statistical outliers relative to definitions published in the Current Procedures Terminology (CPT) code book of the American Medical Association;

(B) at least one shall focus on an alternative method to detailed guidelines based on physician documentation of face to face encounter time with a patient;

(C) at least one shall be conducted for services furnished in a rural area and at least one for services furnished outside such an area; and

(D) at least one shall be conducted in a setting where physicians bill under physicians services in teaching settings and at least one shall be conducted in a setting other than a teaching setting.

(4) BANNING OF TARGETING OF PILOT PROJECT PARTICIPANTS.—Data collected under this subsection shall not be used as the basis for overpayment demands or post-payment audits. Such limitation applies only to claims filed as part of the pilot project and lasts only for the duration of

the pilot project and only as long as the provider is a participant in the pilot project.

(5) STUDY OF IMPACT.—Each pilot project shall examine the effect of the new evaluation and management documentation guidelines on—

(A) different types of physician practices, including those with fewer than 10 full-time-equivalent employees (including physicians); and

(B) the costs of physician compliance, including education, implementation, auditing, and monitoring.

(6) PERIODIC REPORTS.—The Secretary shall submit to Congress periodic reports on the pilot projects under this subsection.

(c) OBJECTIVES FOR EVALUATION AND MANAGEMENT GUIDELINES.—The objectives for new evaluation and management documentation guidelines developed by the Secretary shall be to—

(1) identify clinically relevant documentation needed to code accurately and assess coding levels accurately;

(2) decrease the level of non-clinically pertinent and burdensome documentation time and content in the physician's medical record;

(3) increase accuracy by reviewers; and

(4) educate both physicians and reviewers.

(d) DEFINITIONS.—In this section—

(1) the term ''rural area'' has the meaning given that term in section 1886(d)(2)(D) of the Social Security Act, 42 U.S.C. 1395ww(d)(2)(D); and

(2) the term ''teaching settings'' are those settings described in section 415.150 of title 42, Code of Federal Regulations.

SEC. 406. BENEFICIARY OUTREACH DEMONSTRATION PROGRAM; REPORT ON 1-800 MEDICARE NUMBER.

(a) BENEFICIARY OUTREACH DEMONSTRATION PROGRAM.—

(1) IN GENERAL.—The Secretary shall establish a demonstration program (in this subsection referred to as the ''demonstration program'') under which medicare specialists employed by the Department of Health and Human Services provide advice and assistance to medicare beneficiaries at the location of existing local offices of the Social Security Administration.

(2) LOCATIONS.—

(A) IN GENERAL.—The demonstration program shall be conducted in at least 6 offices or areas. Subject to subparagraph (B), in selecting such offices and areas, the Secretary shall provide preference for offices with a high volume of visits by medicare beneficiaries.

(B) ASSISTANCE FOR RURAL BENEFICIARIES.—The Secretary shall provide for the selection of at least 2 rural areas to participate in the demonstration program. In conducting the demonstration program in such rural areas, the Secretary shall provide for medicare specialists to travel among local offices in a rural area on a scheduled basis.

(3) DURATION.—The demonstration program shall be conducted over a 3-year period.

(4) EVALUATION AND REPORT.—

(A) EVALUATION.—The Secretary shall provide for an evaluation of the demonstration program. Such evaluation shall include an analysis of—

(i) utilization of, and beneficiary satisfaction with, the assistance provided under the program; and

(ii) the cost-effectiveness of providing beneficiary assistance through out-stationing medicare specialists at local offices of the Social Security Administration.

(B) REPORT.—The Secretary shall submit to Congress a report on such evaluation and shall include in such report recommendations regarding the feasibility

of permanently out-stationing medicare specialists at local offices of the Social Security Administration.

(b) REPORT ON 1-800 MEDICARE NUMBER.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study to monitor the accuracy and consistency of information provided to medicare beneficiaries through the toll-free 1-800 Medicare Number, including an assessment of whether the information provided is sufficient to answer beneficiary questions. In conducting the study, the Comptroller General shall examine the education and training of the individuals providing information through the 1-800 Medicare Number.

(2) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1).

SEC. 407. PROVIDER ENROLLMENT APPLICATIONS.

(a) DEADLINES AND MONITORING.—Section 1871 (42 U.S.C. 1395hh), as amended by sections 101(a), 102, and 103, is further amended by adding at the end the following new subsection:

''(g)(1)(A) The Secretary shall establish by regulation procedures under which there are deadlines for actions on applications for enrollment (and, if applicable, renewal of enrollment).

''(B) The Secretary shall monitor the performance of medicare administrative contractors in meeting the deadlines established under subparagraph (A).''.

(b) CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.—

(1) IN GENERAL.—Section 1871(g) (42 U.S.C. 1395hh(g)), as added by subsection (a), is amended by adding at the end the following new paragraph:

''(2) The Secretary shall consult with providers of services, physicians, practitioners, facilities, and suppliers before making changes in the provider enrollment forms required of such providers, physicians, practitioners, facilities, and suppliers to be

eligible to submit claims for which payment may be made under this title.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to changes in provider enrollment forms made on or after January 1, 2002.

TITLE V—REVIEW, RECOVERY, AND ENFORCEMENT REFORM

SEC. 501. PREPAYMENT REVIEW.

(a) IN GENERAL.—Section 1874A, as added by section 301 and as amended by sections 302, 401(b)(1), and 402, is further amended by adding at the end the following new subsection:

''(h) CONDUCT OF PREPAYMENT REVIEW.—

''(1) STANDARDIZATION OF RANDOM PREPAYMENT REVIEW.—If a medicare administrative contractor conducts a random prepayment review, the contractor may only conduct such review in accordance with a standard protocol for random prepayment audits developed by the Secretary.

''(2) LIMITATIONS ON INITIATION OF NON-RANDOM PREPAYMENT REVIEW.—A medicare administrative contractor may not initiate non-random prepayment review of a provider of services, physician, practitioner, facility, or supplier based on the initial identification by that provider of services, physician, practitioner, facility, or supplier of an improper billing practice unless there is a likelihood of sustained or high level of payment error (as defined by the Secretary).

''(3) TERMINATION OF NON-RANDOM PREPAYMENT REVIEW.—The Secretary shall issue regulations relating to the termination, including termination dates, of non-random prepayment review. Such regulations may vary such a termination date based upon the differences in the circumstances triggering prepayment review.

''(4) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the denial of payments for claims actually reviewed under a random prepayment re-

view. In the case of a provider of services, physician, practitioner, facility, or supplier with respect to which amounts were previously overpaid, nothing in this subsection shall be construed as limiting the ability of a medicare administrative contractor to request the periodic production of records or supporting documentation for a limited sample of submitted claims to ensure that the previous practice is not continuing.

''(5) RANDOM PREPAYMENT REVIEW DEFINED.—For purposes of this subsection, the term 'random prepayment review' means a demand for the production of records or documentation absent cause with respect to a claim.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in this subsection, the amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

(2) DEADLINE FOR PROMULGATION OF CERTAIN REGULATIONS.—The Secretary shall first issue regulations under section 1874A(h) of the Social Security Act, as added by subsection (a), by not later than 1 year after the date of the enactment of this Act.

(3) APPLICATION OF STANDARD PROTOCOLS FOR RANDOM PREPAYMENT REVIEW.—Section 1874A(h)(1) of the Social Security Act, as added by subsection (a), shall apply to random prepayment reviews conducted on or after such date (not later than 1 year after the date of the enactment of this Act) as the Secretary shall specify.

(c) APPLICATION TO FISCAL INTERMEDIARIES AND CARRIERS.—The provisions of section 1874A(h) of the Social Security Act, as added by subsection (a), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

SEC. 502. RECOVERY OF OVERPAYMENTS.

(a) IN GENERAL.—Section 1874A, as added by section 301 and as amended by sections 302, 401(b)(1), 402, and

501(a), is further amended by adding at the end the following new subsection:

"(i) RECOVERY OF OVERPAYMENTS.—

"(1) USE OF REPAYMENT PLANS.—

"(A) IN GENERAL.—If the repayment, within the period otherwise permitted by a provider of services, physician, practitioner, facility, or supplier, of an overpayment under this title meets the standards developed under subparagraph (B), subject to subparagraph (C), and the provider, physician, practitioner, facility, or supplier requests the Secretary to enter into a repayment plan with respect to such overpayment, the Secretary shall enter into a plan with the provider, physician, practitioner, facility, or supplier for the offset or repayment (at the election of the provider, physician, practitioner, facility, or supplier) of such overpayment over a period of at least one year, but not longer than 3 years. Interest shall accrue on the balance through the period of repayment. The repayment plan shall meet terms and conditions determined to be appropriate by the Secretary.

"(B) DEVELOPMENT OF STANDARDS.—The Secretary shall develop standards for the recovery of overpayments. Such standards shall—

"(i) include a requirement that the Secretary take into account (and weigh in favor of the use of a repayment plan) the reliance (as described in section 1871(e)(2)) by a provider of services, physician, practitioner, facility, and supplier on guidance when determining whether a repayment plan should be offered; and

"(ii) provide for consideration of the financial hardship imposed on a provider of services, physician, practitioner, facility, or supplier in considering such a repayment plan.

In developing standards with regard to financial hardship with respect to a provider of services, physician,

practitioner, facility, or supplier, the Secretary shall take into account the amount of the proposed recovery as a proportion of payments made to that provider, physician, practitioner, facility, or supplier.

"(C) EXCEPTIONS.—Subparagraph (A) shall not apply if—

"(i) the Secretary has reason to suspect that the provider of services, physician, practitioner, facility, or supplier may file for bankruptcy or otherwise cease to do business or discontinue participation in the program under this title; or

"(ii) there is an indication of fraud or abuse committed against the program.

"(D) IMMEDIATE COLLECTION IF VIOLATION OF REPAYMENT PLAN.—If a provider of services, physician, practitioner, facility, or supplier fails to make a payment in accordance with a repayment plan under this paragraph, the Secretary may immediately seek to offset or otherwise recover the total balance outstanding (including applicable interest) under the repayment plan.

"(E) RELATION TO NO FAULT PROVISION.—Nothing in this paragraph shall be construed as affecting the application of section 1870(c) (relating to no adjustment in the cases of certain overpayments).

"(2) LIMITATION ON RECOUPMENT.—

"(A) NO RECOUPMENT UNTIL RECONSIDERATION EXERCISED.—In the case of a provider of services, physician, practitioner, facility, or supplier that is determined to have received an overpayment under this title and that seeks a reconsideration by a qualified independent contractor on such determination under section 1869(b)(1), the Secretary may not take any action (or authorize any other person, including any medicare contractor, as defined in subparagraph (C)) to recoup the overpayment until the date the decision on the reconsideration has been rendered. If the provisions of

section 1869(b)(1) (providing for such a reconsideration by a qualified independent contractor) are not in effect, in applying the previous sentence any reference to such a reconsideration shall be treated as a reference to a redetermination by the fiscal intermediary or carrier involved.

''(B) PAYMENT OF INTEREST.—

''(i) RETURN OF RECOUPED AMOUNT WITH INTEREST IN CASE OF REVERSAL.—Insofar as such determination on appeal against the provider of services, physician, practitioner, facility, or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest for the period in which the amount was recouped.

''(ii) INTEREST IN CASE OF AFFIRMATION.—Insofar as the determination on such appeal is against the provider of services, physician, practitioner, facility, or supplier, interest on the overpayment shall accrue on and after the date of the original notice of overpayment.

''(iii) RATE OF INTEREST.—The rate of interest under this subparagraph shall be the rate otherwise applicable under this title in the case of overpayments.

''(C) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term 'medicare contractor' has the meaning given such term in section 1889(f).

''(3) PAYMENT AUDITS.—

''(A) WRITTEN NOTICE FOR POST-PAYMENT AUDITS.—Subject to subparagraph (C), if a medicare contractor decides to conduct a post-payment audit of a provider of services, physician, practitioner, facility, or supplier under this title, the contractor shall provide the provider of services, physician, practitioner, facility, or supplier with written notice (which may be in electronic form) of the intent to conduct such an audit.

"(B) EXPLANATION OF FINDINGS FOR ALL AUDITS.—Subject to subparagraph (C), if a medicare contractor audits a provider of services, physician, practitioner, facility, or supplier under this title, the contractor shall—

"(i) give the provider of services, physician, practitioner, facility, or supplier a full review and explanation of the findings of the audit in a manner that is understandable to the provider of services, physician, practitioner, facility, or supplier and permits the development of an appropriate corrective action plan;

"(ii) inform the provider of services, physician, practitioner, facility, or supplier of the appeal rights under this title as well as consent settlement options (which are at the discretion of the Secretary);

"(iii) give the provider of services, physician, practitioner, facility, or supplier an opportunity to provide additional information to the contractor; and

"(iv) take into account information provided, on a timely basis, by the provider of services, physician, practitioner, facility, or supplier under clause (iii).

"(C) EXCEPTION.—Subparagraphs (A) and (B) shall not apply if the provision of notice or findings would compromise pending law enforcement activities, whether civil or criminal, or reveal findings of law enforcement-related audits.

"(4) NOTICE OF OVER-UTILIZATION OF CODES.—The Secretary shall establish, in consultation with organizations representing the classes of providers of services, physicians, practitioners, facilities, and suppliers, a process under which the Secretary provides for notice to classes of providers of services, physicians, practitioners, facilities, and suppliers served by a medicare contractor in cases in which

the contractor has identified that particular billing codes may be overutilized by that class of providers of services, physicians, practitioners, facilities, or suppliers under the programs under this title (or provisions of title XI insofar as they relate to such programs).

''(5) STANDARD METHODOLOGY FOR PROBE SAMPLING.—The Secretary shall establish a standard methodology for medicare contractors to use in selecting a sample of claims for review in the case of an abnormal billing pattern.

''(6) CONSENT SETTLEMENT REFORMS.—

''(A) IN GENERAL.—The Secretary may use a consent settlement (as defined in subparagraph (D)) to settle a projected overpayment.

''(B) OPPORTUNITY TO SUBMIT ADDITIONAL INFORMATION BEFORE CONSENT SETTLEMENT OFFER.—Before offering a provider of services, physician, practitioner, facility, or supplier a consent settlement, the Secretary shall—

''(i) communicate to the provider of services, physician, practitioner, facility, or supplier in a non-threatening manner—

''(I) that, based on a review of the medical records requested by the Secretary, a preliminary evaluation of those records indicates that there would be an overpayment;

''(II) the nature of the problems identified in such evaluation; and

''(III) the steps that the provider of services, physician, practitioner, facility, or supplier should take to address the problems; and

''(ii) provide for a 45-day period during which the provider of services, physician, practitioner, facility, or supplier may furnish additional information concerning the medical records for the claims that had been reviewed.

"(C) CONSENT SETTLEMENT OFFER.—The Secretary shall review any additional information furnished by the provider of services, physician, practitioner, facility, or supplier under subparagraph (B)(ii). Taking into consideration such information, the Secretary shall determine if there still appears to be an overpayment. If so, the Secretary—

"(i) shall provide notice of such determination to the provider of services, physician, practitioner, facility, or supplier, including an explanation of the reason for such determination; and

"(ii) in order to resolve the overpayment, may offer the provider of services, physician, practitioner, facility, or supplier—

"(I) the opportunity for a statistically valid random sample; or

"(II) a consent settlement.

The opportunity provided under clause (ii)(I) does not waive any appeal rights with respect to the alleged overpayment involved.

"(D) CONSENT SETTLEMENT DEFINED.—For purposes of this paragraph, the term 'consent settlement' means an agreement between the Secretary and a provider of services, physician, practitioner, facility, or supplier whereby both parties agree to settle a projected overpayment based on less than a statistically valid sample of claims and the provider of services, physician, practitioner, facility, or supplier agrees not to appeal the claims involved.

"(7) LIMITATION ON USE OF EXTRAPOLATION.—A medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise unless—

"(A) there is a sustained or high level of payment error (as defined by the Secretary by regulation); or

"(B) documented educational intervention has failed to correct the payment error (as determined by the Secretary).".

(b) EFFECTIVE DATES AND DEADLINES.—

(1) Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall first—

(A) develop standards for the recovery of overpayments under section 1874A(i)(1)(B) of the Social Security Act, as added by subsection (a);

(B) establish the process for notice of overutilization of billing codes under section 1874A(i)(4) of the Social Security Act, as added by subsection (a); and

(C) establish a standard methodology for selection of sample claims for abnormal billing patterns under section 1874A(i)(5) of the Social Security Act, as added by subsection (a).

(2) Section 1874A(i)(2) of the Social Security Act, as added by subsection (a), shall apply to actions taken after the date of the enactment of this Act.

(3) Section 1874A(i)(3) of the Social Security Act, as added by subsection (a), shall apply to audits initiated after the date of the enactment of this Act.

(4) Section 1874A(i)(6) of the Social Security Act, as added by subsection (a), shall apply to consent settlements entered into after the date of the enactment of this Act.

(5) Section 1874A(i)(7) of the Social Security Act, as added by subsection (a), shall apply to statistically valid random samples initiated after the date of the enactment of this Act.

SEC. 503. PROCESS FOR CORRECTION OF MINOR ERRORS AND OMISSIONS ON CLAIMS WITHOUT PURSUING APPEALS PROCESS.

(a) IN GENERAL.—The Secretary shall develop, in consultation with appropriate medicare contractors (as defined in section 1889(f) of the Social Security Act, as added by section 401(e)(1)) and representatives of providers of services, physi-

cians, practitioners, facilities, and suppliers, a process whereby, in the case of minor errors or omissions (as defined by the Secretary) that are detected in the submission of claims under the programs under title XVIII of such Act, a provider of services, physician, practitioner, facility, or supplier is given an opportunity to correct such an error or omission without the need to initiate an appeal. Such process shall include the ability to resubmit corrected claims.

(b) DEADLINE.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall first develop the process under subsection (a).

SEC. 504. PROGRAM AND PAYMENT EXCLUSIONS.

(a) AUTHORITY TO WAIVE A PROGRAM EXCLUSION.—The first sentence of section 1128(c)(3)(B) (42 U.S.C. 1320a–7(c)(3)(B)) is amended to read as follows: ''Subject to subparagraph (G), in the case of an exclusion under subsection (a), the minimum period of exclusion shall be not less than five years, except that, upon the request of the administrator of a Federal health care program (as defined in section 1128B(f)) who determines that the exclusion would impose a hardship on beneficiaries under that program, the Secretary may waive the exclusion under subsection (a)(1), (a)(3), or (a)(4) with respect to that program in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community.''.

(b) EXCEPTION FOR CERTAIN PAYMENT EXCLUSIONS.—

(1) IN GENERAL.—Section 1862(a)(11) (42 U.S.C. 1395y(a)(11)) is amended—

(A) by inserting ''(other than a child)'' after ''immediate relatives''; and

(B) by inserting before the semicolon the following; '', unless the items or services are furnished in a rural area (as defined in section 1886(d)(2)(D))''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take apply to items and services furnished on or after January 1, 2003.

TITLE VI—EMTALA IMPROVEMENTS

SEC. 601. PAYMENT FOR EMTALA-MANDATED SCREENING AND STABILIZATION SERVICES.

(a) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is amended by inserting after subsection (c) the following new subsection:

''(d) For purposes of subsection (a)(1)(A), in the case of any item or service that is required to be provided pursuant to section 1867 to an individual who is entitled to benefits under this title, determinations as to whether the item or service is reasonable and necessary shall be made on the basis of the information available to the treating physician or practitioner (including the patient's presenting symptoms or complaint) at the time the item or service was ordered or furnished by the physician or practitioner (and not on the patient's principal diagnosis). When making such determinations with respect to such an item or service, the Secretary shall not consider the frequency with which the item or service was provided to the patient before or after the time of the admission or visit.'''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to items and services furnished on or after January 1, 2002.

SEC. 602. EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA) TASK FORCE.

(a) ESTABLISHMENT.—There is established within the Department of Health and Human Services the Emergency Medical Treatment and Active Labor Act (EMTALA) Task Force (in this section referred to as the ''Task Force''). In this section, the term ''EMTALA'' refers to the provisions of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

(b) MEMBERSHIP.—The Task Force shall be composed of 22 members as follows:

(1) The Administrator of the Centers for Medicare & Medicaid Services.

(2) The Inspector General of the Department of Health and Human Services.

(3) 5 individuals selected by such Administrator—

(A) 4 of whom are staff at regional offices of such Centers involved in investigations of violations of EMTALA, and 1 each from the Northeastern Consortium, Midwestern Consortium, Southern Consortium, and Western Consortium; and

(B) 1 of whom is involved in EMTALA policy at the national level.

(4) 2 individuals who participate in peer review organizations' review of EMTALA determinations.

(5) 4 hospital administrators who have experience with the application of EMTALA.

(6) 8 practicing physicians who have experience with the application of EMTALA, of whom—

(A) 2 are practicing physicians in the field of emergency medicine;

(B) 1 is a practicing physician in the field of general surgery;

(C) 1 is a practicing physician in the field of orthopedic surgery;

(D) 1 is a practicing physician in the field of neurosurgery;

(E) 1 is a practicing physician in the field of ophthalmology;

(F) 1 is a practicing physician in the field of obstetrics and gynecology; and

(G) 1 is a practicing physician in the field of psychiatry.

(7) 1 who is a representative of consumers.

(8) 1 practicing defense attorney specializing in EMTALA defense cases.

The Administrator of the Centers for Medicare & Medicaid Services shall select the members described in paragraphs (3) through (8) and shall provide special consideration to qualified individuals nominated by organizations in the relevant areas of specialty.

(c) GENERAL RESPONSIBILITIES.—The Task Force—

(1) shall review EMTALA regulations;

(2) shall provide advice and recommendations to the Secretary of Health and Human Services with respect to those regulations and their application to hospitals and physicians;

(3) shall solicit comments and recommendations from hospitals, physicians, and the public regarding the implementation of such regulations; and

(4) may disseminate information on the application of such regulations to hospitals, physicians, and the public.

(d) ADMINISTRATIVE MATTERS.—

(1) CHAIRPERSON.—The members of the Task Force shall elect a member to serve as chairperson of the Task Force for the life of the Task Force.

(2) MEETINGS.—The Task Force shall first meet at the direction of the Secretary. The Task Force shall then meet twice per year and at such other times as the Task Force may provide.

(e) TERMINATION.—The Task Force shall terminate 3 years after the date of its first meeting.

(f) EXEMPTION FROM ADVISORY COMMITTEE ACT.—The Task Force shall be exempt from the Federal Advisory Committee Act.

SEC. 603. NOTIFICATION OF PROVIDERS WHEN EMTALA INVESTIGATION CLOSED.

Section 1867(d) (42 U.S.C. 42 U.S.C. 1395dd(d)) is amended by adding at the end the following new paragraph:

''(4) NOTICE UPON CLOSING AN INVESTIGATION.—The Secretary shall establish a procedure to notify hospitals and physicians when an investigation under this section is closed.''.

SEC. 604. PRIOR REVIEW BY PEER REVIEW ORGANIZATIONS IN EMTALA CASES INVOLVING TERMINATION OF PARTICIPATION.

(a) IN GENERAL.—Section 1867(d)(3) (42 U.S.C. 1395dd(d)(3)) is amended—

(1) in the first sentence, by inserting ''or in terminating a hospital's participation under this title'' after ''in imposing sanctions under paragraph (1)''; and

(2) by adding at the end the following new sentences: ''Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this title for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 business days for such review. The organization shall provide of copy of the report on its findings to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to terminations of participation initiated on or after the date of the enactment of this Act.

TITLE VII—MISCELLANEOUS IMPROVEMENTS

SEC. 701. METHODS FOR DETERMINING PAYMENT BASIS FOR NEW LAB TESTS.

Section 1833(h) (42 U.S.C. 1395l(h)) is amended by adding at the end the following:

''(8)(A) The Secretary shall establish by regulation procedures for determining the basis for, and amount of, payment under this subsection for any clinical diagnostic laboratory test with respect to which a new or substantially revised HCPCS code is assigned on or after January 1, 2003 (in this paragraph referred to as 'new tests').

''(B) Determinations under subparagraph (A) shall be made only after the Secretary—

''(i) makes available to the public (through an Internet site and other appropriate mechanisms) a list that includes any such test for which establishment of a payment amount under this subsection is being considered for a year;

"(ii) on the same day such list is made available, causes to have published in the Federal Register notice of a meeting to receive comments and recommendations (and data on which recommendations are based) from the public on the appropriate basis under this subsection for establishing payment amounts for the tests on such list;

"(iii) not less than 30 days after publication of such notice convenes a meeting, that includes representatives of officials of the Centers for Medicare & Medicaid Services involved in determining payment amounts, to receive such comments and recommendations (and data on which the recommendations are based);

"(iv) taking into account the comments and recommendations (and accompanying data) received at such meeting, develops and makes available to the public (through an Internet site and other appropriate mechanisms) a list of proposed determinations with respect to the appropriate basis for establishing a payment amount under this subsection for each such code, together with an explanation of the reasons for each such determination, the data on which the determinations are based, and a request for public written comments on the proposed determination; and

"(v) taking into account the comments received during the public comment period, develops and makes available to the public (through an Internet site and other appropriate mechanisms) a list of final determinations of the payment amounts for such tests under this subsection, together with the rationale for each such determination, the data on which the determinations are based, and responses to comments and suggestions received from the public.

"(C) Under the procedures established pursuant to subparagraph (A), the Secretary shall—

"(i) set forth the criteria for making determinations under subparagraph (A); and

"(ii) make available to the public the data (other than proprietary data) considered in making such determinations.

"(D) The Secretary may convene such further public meetings to receive public comments on payment amounts for new tests under this subsection as the Secretary deems appropriate.

"(E) For purposes of this paragraph:

"(i) The term 'HCPCS' refers to the Health Care Procedure Coding System.

"(ii) A code shall be considered to be 'substantially revised' if there is a substantive change to the definition of the test or procedure to which the code applies (such as a new analyte or a new methodology for measuring an existing analyte-specific test).".

SEC. 702. ONE YEAR DELAY IN LOCK IN PROCEDURES FOR MEDICARE+CHOICE PLANS.

Section 1851(e) (42 U.S.C. 1395w–21(e)) is amended—

(1) in paragraph (2)(A), by striking "THROUGH 2001" and "and 2001" and inserting "THROUGH 2002" and "2001, and 2002", respectively;

(2) in paragraph (2)(B), by striking "DURING 2002" and inserting "DURING 2003";

(3) in paragraphs (2)(B)(i) and (2)(C)(i), by striking "2002" and inserting "2003" each place it appears;

(4) in paragraph (2)(D), by striking "2001" and inserting "2002"; and

(5) in paragraph (4), by striking "2002" and inserting "2003" each place it appears.